LONDON BOROUGH OF HACKNEY INTEGRATED COMMISSIONING BOARD

Thursday, 10th October, 2019

at 10.15 am

Committee Membership:

Councillor Anntoinette Bramble
Councillor Rebecca Rennison
Councillor Feryal Clark

Tim Shields
Chief Executive

Contact:
Clifford Hart
Governance Services
Tel: 020 8356 3597
Email: clifford.hart@Hackney.gov.uk

The press and public are welcome to attend this meeting

Hackney

AGENDA
Thursday, 10th October, 2019

ORDER OF BUSINESS

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1	**London Borough of Hackney Integrated Commissioning Board Agenda**	1 - 592
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Access and Information

Location

Hackney Town Hall is on Mare Street, bordered by Wilton Way and Reading Lane, almost directly opposite Hackney Picturehouse

Trains – Hackney Central Station (London Overground) **–** Turn right on leaving the station, turn right again at the traffic lights into Mare Street, walk 200 metres and look for the Hackney Town Hall, almost next to The Empire immediately after Wilton Way.

Buses 30, 48, 55, 106, 236, 254, 277, 394, D6 and W15.

Facilities

There are public toilets available, with wheelchair access, on the ground floor of the Town Hall. Induction loop facilities are available in the Assembly Halls, rooms 101, 102 & 103 and the Council Chamber. Access for people with mobility difficulties can be obtained through the ramp on the side to the main Town Hall entrance.

Copies of the Agenda

The Hackney website contains a full database of meeting agendas, reports and minutes. Log on at: www.hackney.gov.uk

Paper copies are also available from the Governance Services Officers whose contact details are shown on page 1 of the agenda.

Council & Democracy- www.hackney.gov.uk

The Council & Democracy section of the Hackney Council website contains details about the democratic process at Hackney, including:

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RIGHTS OF PRESS AND PUBLIC TO REPORT ON MEETINGS

Where a meeting of the Council and its committees are open to the public, the press and public are welcome to report on meetings of the Council and its committees, through any audio, visual or written methods and may use digital and social media providing they do not disturb the conduct of the meeting and providing that the person reporting or providing the commentary is present at the meeting.

Those wishing to film, photograph or audio record a meeting are asked to notify the Council's Monitoring Officer by noon on the day of the meeting, if possible, or any time prior to the start of the meeting or notify the Chair at the start of the meeting.

The Monitoring Officer, or the Chair of the meeting, may designate a set area from which all recording must take place at a meeting.

The Council will endeavour to provide reasonable space and seating to view, hear and record the meeting. If those intending to record a meeting require any other reasonable facilities, notice should be given to the Monitoring Officer in advance of the meeting and will only be provided if practicable to do so.

The Chair shall have discretion to regulate the behaviour of all those present recording a meeting in the interests of the efficient conduct of the meeting. Anyone acting in a disruptive manner may be required by the Chair to cease recording or may be excluded from the meeting. Disruptive behaviour may include: moving from any designated recording area; causing excessive noise; intrusive lighting; interrupting the meeting; or filming members of the public who have asked not to be filmed.

All those visually recording a meeting are requested to only focus on recording councillors, officers and the public who are directly involved in the conduct of the meeting. The Chair of the meeting will ask any members of the public present if they have objections to being visually recorded. Those visually recording a meeting are asked to respect the wishes of those who do not wish to be filmed or photographed. Failure by someone recording a meeting to respect the wishes of those who do not wish to be filmed and photographed may result in the Chair instructing them to cease recording or in their exclusion from the meeting.

If a meeting passes a motion to exclude the press and public then in order to consider confidential or exempt information, all recording must cease and all recording equipment must be removed from the meeting room. The press and public are not permitted to use any means which might enable them to see or hear the proceedings whilst they are excluded from a meeting and confidential or exempt information is under consideration.

Providing oral commentary during a meeting is not permitted.

ADVICE TO MEMBERS ON DECLARING INTERESTS

Hackney Council's Code of Conduct applies to **all** Members of the Council, the Mayor and co-opted Members.

This note is intended to provide general guidance for Members on declaring interests. However, you may need to obtain specific advice on whether you have an interest in a particular matter. If you need advice, you can contact:

- The Director of Legal, Services;
- The Legal Adviser to the committee; or
- Governance Services.

If at all possible, you should try to identify any potential interest you may have before the meeting so that you and the person you ask for advice can fully consider all the circumstances before reaching a conclusion on what action you should take.

1. Do you have a disclosable pecuniary interest in any matter on the agenda or which is being considered at the meeting?

You will have a disclosable pecuniary interest in a matter if it:

i. relates to an interest that you have already registered in Parts A and C of the Register of Pecuniary Interests of you or your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner;

ii. relates to an interest that should be registered in Parts A and C of the Register of Pecuniary Interests of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner, but you have not yet done so; or

iii. affects your well-being or financial position or that of your spouse/civil partner, or anyone living with you as if they were your spouse/civil partner.

2. If you have a disclosable pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you (subject to the rules regarding sensitive interests).

ii. You must leave the room when the item in which you have an interest is being discussed. You cannot stay in the meeting room or public gallery whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision.

iii. If you have, however, obtained dispensation from the Monitoring Officer or Standards Committee you may remain in the room and participate in the meeting. If dispensation has been granted it will stipulate the extent of your

involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a pecuniary interest.

3. Do you have any other non-pecuniary interest on any matter on the agenda which is being considered at the meeting?

You will have 'other non-pecuniary interest' in a matter if:

i. It relates to an external body that you have been appointed to as a Member or in another capacity; or

ii. It relates to an organisation or individual which you have actively engaged in supporting.

4. If you have other non-pecuniary interest in an item on the agenda you must:

i. Declare the existence and nature of the interest (in relation to the relevant agenda item) as soon as it becomes apparent to you.

ii. You may remain in the room, participate in any discussion or vote provided that contractual, financial, consent, permission or licence matters are not under consideration relating to the item in which you have an interest.

iii. If you have an interest in a contractual, financial, consent, permission or licence matter under consideration, you must leave the room unless you have obtained a dispensation from the Monitoring Officer or Standards Committee. You cannot stay in the room or public gallery whilst discussion of the item takes place and you cannot vote on the matter. In addition, you must not seek to improperly influence the decision. Where members of the public are allowed to make representations, or to give evidence or answer questions about the matter you may, with the permission of the meeting, speak on a matter then leave the room. Once you have finished making your representation, you must leave the room whilst the matter is being discussed.

iv. If you have been granted dispensation, in accordance with the Council's dispensation procedure you may remain in the room. If dispensation has been granted it will stipulate the extent of your involvement, such as whether you can only be present to make representations, provide evidence or whether you are able to fully participate and vote on the matter in which you have a non pecuniary interest.

Further Information

Advice can be obtained from Suki Binjal, Interim Director of Legal, Services, on 020 8356 6237 or email suki.binjal@hackney.gov.uk

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City Integrated Commissioning Board
Meeting in-common of the City and Hackney Clinical Commissioning Group and the City of London Corporation

Hackney Integrated Commissioning Board
Meeting in-common of the City and Hackney Clinical Commissioning Group and the London Borough of Hackney

Joint Meeting in public of the two Integrated Commissioning Boards on Thursday 10 October 2019, 10.15 – 12.00, Hackney Town Hall, Room 102 & 103

Item no.	Item	Lead and purpose	Documentation type	Page No.	Time
1.	**Welcome, introductions and apologies**	Chair	Verbal	-	10.15
2.	**Declarations of Interests**	Chair *For noting*	Paper	3-8	
3.	**Questions from the Public**	Chair	Verbal	-	
4.	**Minutes of the Previous Meeting and Action Log**	Chair *For approval*	Paper	9-18	
Governance					
5.	**Progress report & review**	Carol Beckford *For noting*	Paper	19-25	10.20
6.	**Integrated Commissioning Register of Escalated Risks** **Integrated Commissioning Finance Update**	Carol Beckford *For noting* Sunil Thakker / Ian Williams / Mark Jarvis *For noting*	Paper Paper	26-30 31-44	10.30
7.	**S75 Integrated Learning Disability Service Agreement**	Carlene Liverpool *For approval*	Paper	45-203	10.35
Strategies & transformation					

8.	**STP Long-term plan**	Nicholas Ib *For noting*	Paper	204-359	10.50
9.	**Prevention Investment Standard**	Jayne Taylor *For noting*	Paper	360-366	11.10
10.	**City & Hackney Mental Health Strategy**	Dan Burningham *For approval*	Paper	367-452	11.25
Performance updates					
11.	**Planned Care detailed review**	Siobhan Harper *For noting*	Paper	453-491	11.40
.	**AOB & Reflections**	Chair *For discussion*	Verbal	-	-
-	**Integrated Commissioning Glossary**	*For information*	IC Glossary	492	-
-	**City & Hackney Systems Intentions 2019/20**	*For information*	Annex	-	-
-	**PwC Governance Review Update**	*For information*	Annex	-	-

Date of next meeting:

14 November 2019, Committee Room 3, West Wing, Guildhall

Integrated Commissioning
2019 Register of Interests

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Simon	Cribbens	12/08/2019	City ICB advisor/ regular attendee Accountable Officers Group member	City of London Corporation	Assistant Director - Commissioning & Partnerships, Community & Children's Services	Pecuniary Interest
				City of London Corporation	Attendee at meetings	Pecuniary Interest
				Porvidence Row	Trustee	Non-Pecuniary Interest
Sunil	Thakker	11/12/2018	Transformation Board Member - CHCCG City and Hackney ICB advisor/ regular attendee	City & Hackney CCG	Chief Financial Officer	Non-Pecuniary Interest
Ian	Williams	10/05/2017	Hackney ICB advisor/ regular attendee	London Borough of Hackney	Group Director, Finance and Corporate Resources	Pecuniary Interest
				n/a	Homeowner in Hackney	Pecuniary Interest
				Hackney Schools for the Future Ltd	Director	Pecuniary Interest
				NWLA Partnership Board	Joint Chair	Pecuniary Interest
				Chartered Institute of Public Finance and Accountancy	Member	Non-Pecuniary Interest
				Society of London Treasurers	Member	Non-Pecuniary Interest
				London Finance Advisory Committee	Member	Non-Pecuniary Interest
				Schools and Academy Funding Group	London Representative	Non-Pecuniary Interest
				London Pensions Investments Advisory Committee	Chair	Non-Pecuniary Interest
Ruby	Sayed	11/12/2018	City ICB member	City of London Corporate	Member	Pecuniary Interest
				Gaia Re Ltd	Member	Pecuniary Interest
				Thincats (Poland) Ltd	Director	Pecuniary Interest
				Bar of England and Wales	Member	Pecuniary Interest
				Transition Finance (Lavenham) Ltd	Member	Pecuniary Interest
				Nirvana Capital Ltd	Member	Pecuniary Interest
				Honourable Society of the Inner Temple	Member	Non-pecuniary interest
				Independent / Temple & Farringdon Together	Member	Non-pecuniary interest
				Guild of Entrepreneurs	Founder Members	Non-pecuniary interest
				Bury St. Edmund's Woman's Aid	Trustee	Non-pecuniary interest
				Asian Women's Resource Centre	Trustee	Non-pecuniary interest
Mark	Jarvis	10/04/2017	City ICB advisor / regular attendee	City of London Corporation	Head of Finance	Pecuniary Interest
Anne	Canning	27/06/2019	Hackney ICB advisor / regular attendee Accountable Officers Group member	London Borough of Hackney	Group Director - Children, Adults & Community Health	Pecuniary Interest
					Partner works at Our Lady's Convent School, N16	Indirect interest
Honor	Rhodes	01/03/2019	Member - City / Hackney Integrated Commissioning Boards	City & Hackney Clinical Commissioning Group	Lay Member for Governance	Pecuniary Interest
				Tavistock Centre for Couple Relationships	Director	Non-Pecuniary Interest
				Southwark Giving	Chair	Non-Pecuniary Interest
				The School and Family Works, Social Enterprise	Special Advisor	Pecuniary Interest
				HUHFT	Daughter is employed as Assistant Psychologist	Indirect interest
				Oxleas NHS Foundation Trust	Spouse is Tri-Borough Consultant Family Therapist	Indirect interest
				Early Intervention Foundation	Trustee	Non-Pecuniary Interest
				n/a	Registered with Barton House NHS Practice, N16	Non-Pecuniary Interest
Gary	Marlowe	25/06/2019	GP Member of the City & Hackney CCG Governing Body ICB advisor / regular attendee	City & Hackney CCG Governing Body	GP Member	Pecuniary Interest
				De Beauvoir Surgery	GP Partner	Pecuniary Interest
				City & Hackney CCG	Planned Care Lead	Pecuniary Interest
				Hackney GP Confederation	Member	Pecuniary Interest
				British Medical Association	London Regional Chair	Non-Pecuniary Interest
				n/a	Homeowner - Casimir Road, E5	Non-Pecuniary Interest
				City of London Health & Wellbeing Board	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				Local Medical Committee	Member	Non-Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				CHUHSE	Member	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Anntoinette	Bramble	05/06/2019	Member - Hackney Integrated Commissioning Board	Hackney Council	Deputy Mayor	Pecuniary Interest
				Local Government Association	Member of the Children and Young Board	Pecuniary Interest
				Schools Forum	Member	Pecuniary Interest
				SACRE	Member	Pecuniary Interest
				Admission Forum	Member	Pecuniary Interest
				HSFL (Ltd)		Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Urstwick School	Governor	Non-Pecuniary Interest
				City Academy	Governor	Non-Pecuniary Interest
				Hackney Play Bus (Charity)	Board Member	Non-Pecuniary Interest
				Local Government Association	Member	Non-Pecuniary Interest
				Lower Clapton Group Practice	Registered Patient	Non-pecuniary interest
Feryal	Clark	15/02/2019	Member - Hackney Integrated Commissioning Board (ICB Chair July 2018 - March 2019)	Hackney Council	Deputy Mayor and Cabinet Member for Health, Social Care, Leisure and Parks	Pecuniary Interest
				London Councils Transport and Environment Committee	Member	Pecuniary Interest
				London Waste recycling Board	Member	Pecuniary Interest
				Unison	Member	Non-Pecuniary Interest
				Labour party	Member	Non-Pecuniary Interest
				Hackney Health and Wellbeing Board	Chair	Non-Pecuniary Interest
				Local GP practice	Registered patient	Non-Pecuniary Interest
Marianne	Fredericks	21/11/2018	Member - City Integrated Commissioning Board	City of London	Member	Pecuniary Interest
				Farringdon Ward Club	Member	Non-Pecuniary Interest
				The Worshipful Company of Firefighters	Liveryman	Non-Pecuniary Interest
				Christ's Hospital School Council	Member	Non-Pecuniary Interest
				Aldgate and All Hallows Foundation Charity	Member	Non-Pecuniary Interest
				The Worshipful Company of Bakers	Liveryman	Non-Pecuniary Interest
				Tower Ward Club	Member	Non-Pecuniary Interest
Christopher	Kennedy	25/06/2019	Deputy Member - Hackney Integrated Commissioning Board	Hackney Council	Cabinet Member for Families, Early Years and Play	Pecuniary Interest
				Lee Valley Regional Park Authority	Member	Non-Pecuniary Interest
				Hackney Empire	Member	Non-Pecuniary Interest
				Hackney Parochial Charity	Member	Non-Pecuniary Interest
				Labour party	Member	Non-Pecuniary Interest
				Local GP practice	Registered patient	Non-Pecuniary Interest
Dhruv	Patel	12/08/2019	Member - City Integrated Commissioning Board	City of London Corporation	Deputy Chairman, City of London Corporation Integrated Commissioning Sub-Committee	Pecuniary Interest
				Clockwork Pharmacy Group SSAS, Amersham	Trustee; Member	Pecuniary Interest
				Clockwork Underwriting LLP, Lincolnshire	Partner	Pecuniary Interest
				Clockwork Retail Ltd, London	Company Secretary & Shareholder	Pecuniary Interest
				Clockwork Pharmacy Ltd	Company Secretary	Pecuniary Interest
				DP Facility Management Ltd	Director; Shareholder	Pecuniary Interest
				Clockwork Farms Ltd	Director; Shareholder	Pecuniary Interest
				P&A Developments	Company Secretary	Pecuniary Interest
				Clockwork Hotels LLP	Partner	Pecuniary Interest
				Capital International Ltd	Employee	Pecuniary Interest
					Land Interests - 8/9 Ludgate Square 215-217 Victoria Park Road 236-238 Well Street 394-400 Mare Street 1-11 Dispensary Lane	Pecuniary Interest
					Securities - Fundsmith LLP Equity Fund Class Accumulation GBP J P Morgan American Investment Trust PLC Ord	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				City of London Academies Trust	Director	Non-Pecuniary Interest
				The Lord Mayor's 800th Anniversary Awards Trust	Trustee	Non-Pecuniary Interest
				City Hindus Network	Director; Member	Non-Pecuniary Interest
				Aldgate Ward Club	Member	Non-Pecuniary Interest
				City & Guilds College Association	Life-Member	Non-Pecuniary Interest
				The Society of Young Freemen	Member	Non-Pecuniary Interest
				City Livery Club	Member and Treasurer of u40s section	Non-Pecuniary Interest
				The Clothworkers' Company	Liveryman; Member of the Property Committee	Non-Pecuniary Interest
				Diversity (UK)	Member	Non-Pecuniary Interest
				Chartered Association of Buidling Engineers	Member	Non-Pecuniary Interest
				Institution of Engineering and Technology	Member	Non-Pecuniary Interest
				City & Guilds of London Institute	Associate	Non-Pecuniary Interest
				Association of Lloyd's members	Member	Non-Pecuniary Interest
				High Premium Group	Member	Non-Pecuniary Interest
				Avanti Court Primary School	Chairman of Governors	Non-Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
Randall	Anderson	15/07/2019	Member - City Integrated Commissioning Board	City of London Corporation	Chair, Community and Children's Services Committee	Pecuniary Interest
				n/a	Self-employed Lawyer	Pecuniary Interest
				n/a	Renter of a flat from the City of London (Breton House, London)	Non-Pecuniary Interest
				Member	American Bar Association	Non-Pecuniary Interest
				Masonic Lodge 1745	Member	Non-Pecuniary Interest
				Worshipful Company of Information Technologists	Freeman	Non-Pecuniary Interest
				City of London School for Girls	Member - Board of Governors	Non-Pecuniary Interest
				Neaman Practice	Registered Patient	Non-Pecuniary Interest
Andrew	Carter	12/08/2019	City ICB advisor / regular attendee	City of London Corporation	Director of Community & Children's Services	Pecuniary Interest
				Petchey Academy & Hackney / Tower Hamlets College	Governing Body Member	Non-pecuniary interest
				n/a	Spouse works for FCA (fostering agency)	Indirect interest
David	Maher	19/06/2019	Accountable Officers Group Member ICB regular attendee/ AO deputy	City and Hackney Clinical Commissioning Group	Managing Director	Pecuniary Interest
				World Health Organisation	Member of Expert Group to the Health System Footprint on Sustainable Development	Non-Pecuniary Interest
				NHS England, Sustainable Development Unit	Social Value and Commissioning Ambassador	Non-Pecuniary Interest
Rebecca	Rennison	31/05/2019	Member - Hackney Integrated Commissioning Board	Target Ovarian Cancer	Director of Public Affairs and Services	Pecuniary Interest
				Hackney Council	Cabinet Member for Finance and Housing Needs	Pecuniary Interest
				Cancer52Board	Member	Non-Pecuniary Interest
				Clapton Park Tenant Management Organisation	Board Member	Non-Pecuniary Interest
				North London Waste Authority	Board Member	Non-Pecuniary Interest
					Land Interests - Residential property, Angel Wharf	Non-Pecuniary Interest
					Residential Property, Shepherdess Walk, N1	Non-Pecuniary Interest
				GMB Union	Member	Non-Pecuniary Interest
				Labour Party	Member	Non-Pecuniary Interest
				Fabian Society	Member	Non-Pecuniary Interest
				English Heritage	Member	Non-Pecuniary Interest
				Chats Palace	Board Member	Non-Pecuniary Interest
Carol	Beckford	09/07/2019	Integrated Commissioning Programme Director (Interim)	Hunter Health Group	Agency Worker	Non-Pecuniary Interest
Henry	Black	27/06/2019	NEL Commissioning Alliance - CFO	Barking, Havering & Redbridge University Hospitals NHS Trust	Wife is Assistant Director of Finance	Indirect interest
				East London Lift Accommodation Services Ltd	Director	Non-financial professional interest
				East London Lift Accommodation Services No2 Ltd	Director	Non-financial professional interest
				East London Lift Holdco No2 Ltd	Director	Non-financial professional interest
				East London Lift Holdco No3 Ltd	Director	Non-financial professional interest
				East London Lift Holdco No4 Ltd	Director	Non-financial professional interest
				ELLAS No3 Ltd	Director	Non-financial professional interest
				ELLAS No4 Ltd	Director	Non-financial professional interest
				Infracare East London Ltd	Director	Non-financial professional interest
Jane	Milligan	26/06/2019	Member - Integrated Commissioning Board	NHS North East London Commissioning Alliance (City & Hackney, Newham, Tower Hamlets, Waltham Forest, Barking and Dagenham, Havering and Redbridge CCGs)	Accountable Officer	Pecuniary Interest
				North East London Sustainability and Transformation Partnership	Senior Responsible Officer	Pecuniary Interest

Forename	Surname	Date of Declaration	Position / Role	Nature of Business / Organisation	Nature of Interest / Comments	Type of interest
				n/a	Partner is employed substantively by NELCSU as Director of Business Development from 2 January 2018 on secondment to Central London Community Services Trust.	Indirect Interest
				Stonewall	Ambassador	Non-Pecuniary Interest
				Peabody Housing Association Board	Non-Executive Director	Non-pecuniary interest
Ellie	Ward	22/01/2018	Integration Programme Manager, City of London Corporation	City of London Corporation	Integration Programme Manager	Pecuniary Interest
Mark	Rickets	16/05/2018	Member - City and Hackney Integrated Commissioning Boards	City and Hackney Clinical Commissioning Group	Chair	Pecuniary Interest
			Primary Care Quality Programme Board Chair (GP Lead)	Health Systems Innovation Lab, School Health and Social Care, London South Bank University	Wife is a Visiting Fellow	Non-financial professional interest
			Primary Care Quality Programme Board Chair (GP Lead)	GP Confederation	Nightingale Practice is a Member	Professional financial interest
			CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	HENCEL	I work as a GP appraiser in City and Hackney and Tower Hamlets for HENCEL	Professional financial interest
			CCG Chair Primary Care Quality Programme Board Chair (GP Lead)	Nightingale Practice (CCG Member Practice)	Salaried GP	Professional financial interest
Jake	Ferguson		Chief Executive Officer Member	Hackney Council for Voluntary Service Voluntary Sector Transformation Leadership Group which represents the sector across the Transformation / ICS structures.	Organisation holds various grants from the CCG and Council. Full details available on request.	Professional financial interest Non-financial personal interest
Jon	Williams	29/03/2017	Attendee - Hackney Integrated Commisioning Board	Healthwatch Hackney	Director Hackney Council Core and Signposting Grant - CHCCG NHS One Hackney & City Patient Support Contract - CHCCG NHS Community Voice Contract - CHCCG Involvement Alliance Contract - CHCCG Devolution Communications and Engagment Contract Based in St Leonard's Hospital	Pecuniary Interest

Meeting-in-common of the Hackney Integrated Commissioning Board
(comprising the City & Hackney CCG Integrated Commissioning Committee and the London Borough of Hackney Integrated Commissioning Committee)

and

Meeting-in-common of the City Integrated Commissioning Board
(comprising the City & Hackney CCG Integrated Commissioning Committee and the City of London Corporation Integrated Commissioning Committee)

Minutes of meeting held in public on 12 September 2019,
In Committee Room 3, West Wing, Guildhall EC2V 7HH

Present:

Hackney Integrated Commissioning Board

Hackney Integrated Commissioning Committee

Cllr Feryal Clark	Deputy Mayor and Cabinet Member for Health, Social Care, Leisure and Parks	London Borough of Hackney
Philip Glanville	Mayor of Hackney	London Borough of Hackney

City & Hackney CCG Integrated Commissioning Committee

Mark Rickets	CCG Chair (ICB Chair)	City & Hackney CCG
Honor Rhodes	Governing Body Lay member	City & Hackney CCG
Jane Milligan	Accountable Officer	East London Health and Care Partnership

City Integrated Commissioning Board

City Integrated Commissioning Committee

Randall Anderson	Chairman, Community and Children's Services Committee	City of London Corporation
Ruby Sayed	Member, Community and Children's Services Committee	City of London Corporation
Marianne Fredericks	Member, Community and Children's Services Committee	City of London Corporation

In attendance

Ann Sanders	Lay member	City & Hackney CCG
Anne Canning	Group Director, Children, Adults and Community Health	London Borough of Hackney
Henry Black	Chief Finance Officer	East London Health and Care Partnership
Gary Marlowe	Governing Body GP member	City & Hackney CCG
Andrew Carter	Director, Community & Children's	City of London Corporation

	Services	
Carolyn Kus	Director of Programme Delivery	London Borough of Hackney, City of London Corporation, and City & Hackney CCG
Jake Ferguson	Chief Executive	Hackney Council for Voluntary Services
Ian Williams	Group Director, Finance and Corporate Services	London Borough of Hackney
Sunil Thakker	Director of Finance	City & Hackney CCG
Siobhan Harper	Planned Care Workstream Director	City & Hackney CCG
Ben Knowles	Head of External Communications	Hackney Council
Amy Harmsworth	Public Health Strategist	Hackney Council
Apologies – ICB members		
Councillor Rebecca Rennison	Cabinet Member for Finance and Housing Needs	City & Hackney CCG
Councillor Antoinette Bramble	Deputy Mayor & Cabinet Member for Education, Young People & Children's Social Care	Hackney Council
Other apologies		City & Hackney CCG
Cllr Christopher Kennedy	Cabinet Member, Families, Early Years and Play	London Borough of Hackney
Tim Shields	Chief Executive	Hackney Council
Mark Jarvis	Head of Finance	City of London Corporation
Simon Cribbens	Assistant Director Commissioning & Partnerships, Community & Children's Services	City of London Corporation

1. WELCOME, INTRODUCTIONS AND APOLOGIES

1.1. The Chair, Mark Rickets, opened the meeting.

1.2. Apologies were noted as listed above.

1.3. Mark introduced Ann Sanders, the new Lay member for City & Hackney CCG and Carolyn Kus, the new Director of Programme Delivery – based in the London Borough

of Hackney but working across the City of London, the London Borough of Hackney and City & Hackney CCG.

2. DECLARATIONS OF INTERESTS

ACTION: Alex Harris to check the declarations of Interest register to ensure all members are on the list.

ACTION: Following on from action ICBJUN-1, Jonathan McShane to ensure there is a written record of any meetings held externally.

ACTION: Following on from action ICBJUL-1, Anne Canning to speak with Councillor Kennedy on the update around the redesign of housing related support.

2.1. The **City Integrated Commissioning Board**

- **NOTED** the Register of Interests.

2.2. The **Hackney Integrated Commissioning Board**

- **NOTED** the Register of Interests.

3. QUESTIONS FROM THE PUBLIC

3.1. There were no questions from members of the public.

4. MINUTES OF PREVIOUS MEETING AND ACTION LOG

4.1. The **City Integrated Commissioning Board:**

- **APPROVED** the minutes of the Joint ICB meeting held in public on 11 July 2019.
- **NOTED** the updates on the action log.

4.2. The **Hackney Integrated Commissioning Board**:

- **APPROVED** the minutes of the Joint ICB meeting held in public on 11 July 2019.
- **NOTED** the updates on the action log.

5. Better Care Fund 2019-20

5.1 Siobhan Harper introduced the item. She noted that the BCF is a programme spanning both the NHS and local government which seeks to join-up health and care services. She confirmed the financial increases on the BCF for the City & Hackney. The final submission to NHS England will be on 27 September and will be circulated to ICB members for information.

5.2 Councillor Clark noted that its disappointing that a full response had not been received on the uplift for the City & Hackney and further information from NHS England was needed on this.

5.3 Ann Canning commented that there is lack of clarity across the system around the allocations and uplift.

5.4 **The City Integrated Commissioning Board**

- **APPROVED** the BCF funding plan.

5.5 **The Hackney Integrated Commissioning Board**

- **APPROVED** the BCF funding plan.

ACTION: Siobhan Harper to circulate the final paper submitted to ICB members.

6. Integrated Commissioning Communications & Engagement Strategy/Branding

6.1 Ben Knowles introduced this item. He provided an update on the work carried out over the past eight months to professionalise and improve communications and engagement around IC and presented some options around branding for IC.

6.2 Randall Anderson commented that the City colours and the NHS need to be reflected within the logo.

6.3 Jane Milligan said it was important to get the logo and strapline right in a way that is right for the people who are providing services.

6.4 Councillor Clark also noted that the logo doesn't currently reflect health in this widest sense.

6.5 Jake Ferguson asked a question around the budgets, does the spend reflect patient representatives attending meetings and being involved in the design of the logo. Jon Williams responded, the estimated budget allocation for involvement and participant access needs payments is an estimate of what has been allocated.

6.6 Gary Marlowe commented that the logo needs to unite the key organisations and enable practitioners feel a part of the system.

6.7 Mark Rickets agreed that the logo needs to reflect health and also needs to incorporate the City & Hackney colours.

6.8 Marianne Fredricks also agreed that the colours need to reflect both the City & Hackney. It was suggested that Marianne joins the group who are designing the logo to provide input from a City perspective.

6.9 Mark Rickets asked ICB members to agree on the strapline supporting the logo, the logo will need to go back to the design team for further work.

6.10 Andrew Carter suggested that any changes made to the logo need to be communicated with the public, the message to send out needs to be clear on why we are changing the logo further.

6.11 Ellie Ward was asked to link up the City branding manager with Ben Knowles.

6.12 **The City Integrated Commissioning Board**

- **APPROVED** the strapline supporting the logo "Health, Care and Community Partners" & the Comms & Engagement Plan

6.13 **The Hackney Integrated Commissioning Board**

- **APPROVED** the strapline supporting the logo "Health, Care and Community Partners" & the Comms & Engagement Plan.

- **ACTION: Marianne Frederick to join the design group to refine the logo further.**
- **ACTION: Ellie Ward to link up the Branding Manager from the City with Ben Knowles.**
- **[POST-MEETING ACTION, AGREED WITH THE CHAIR]: An update on the development of the logo to be brought to the November ICB.**

7. System Maturity Matrix

7.1 Jonathan McShane introduced this item. Recently all STPs were asked to produce a 'system maturity matrix' which was a self-assessment of ICS readiness across a number of domains. NHS England have now asked for the STPs to submit their maturity matrix so they can review them across England in a 'light touch' way. This will not be part of the formal assessment process.

7.2 Jane Milligan added that each of the local systems maturity matrix will feed into the Long Term Plan submissions which will be made later in September.

7.3 **The City Integrated Commissioning Board**

- **NOTED** the maturity matrix submission

7.4 **The Hackney Integrated Commissioning Board**

- **NOTED** the maturity matrix submission

8. City & Hackney Summary Response to the NHS Long Term Plan – an update

8.1 David Maher introduced this item. This report provides an update on the City and Hackney contribution to the STP response to NHS Long Term Plan. This document has been through various groups and organisations for engagement and good feedback has been received.

8.2 Jane Milligan confirmed that alongside the narrative, there will be a finance submission and a performance trajectories submission which will need to be submitted on 27 September. The challenge for the STP is joining up the three local systems narrative and ensuring that it reads as one, this work is being undertaken by a central STP team.

8.3 Jake Ferguson noted that on page 66 there was no reference made to VCS and asked if this can this be considered within the diagram. He suggested engaging with people in the community with lived experience.

8.4 Jon Williams noted that we need to ensure that any move towards a single CCG across North East London needs to be communicated to the public and he offered to support this.

8.5 Randall Anderson noted that with the changes happening with the proposed merger of the CCGs, we need to ensure there will be capacity within the local system to deliver the 'ask' of the Long Term Plan.

8.6 Councillor Clark expressed concerns around the proposed merging of CCGs, noting that we need to ensure this merger won't have a negative impact on the local system. She asked to see the STP Long Term Plan submission before it is sent to NHS England.

8.7 **The City Integrated Commissioning Board**

- **NOTED** the local summary response to the NHS Long Term Plan for the City & Hackney system.

8.8 **The Hackney Integrated Commissioning Board**

- **NOTED** the local summary response to the NHS Long Term Plan for the City & Hackney system.

- **Nic Ib to update page 66 of the long-term plan document to make reference to the VCS.**
- **David Maher welcomed the support from Health Watch and stated that he will confirm timescales of when we will need to engage with the public.**

9. System Commissioning Intentions 2020/21 - update

9.1 David Maher introduced this item. The move towards an Integrated Care System by the 1st April 2021 sets a requirement within City & Hackney to migrate from 'commissioning intentions' to 'system intentions'. David noted that the workstreams have been working closely with the Providers and this is reflected within the City and Hackney response to the NHS Long Term Plan. This paper will be going to the governing body by end of September for sign off. It will come back in October with more detail.

9.2 The **City Integrated Commissioning Board**

- **NOTED** the report.

9.3 The **Hackney Integrated Commissioning Board**

- **NOTED** the report.

- **David Maher and Carol Beckford to ensure that ICB receive a copy of City & Hackney's 2020/21 System Intentions for the October meeting.**

10 Adult Substance Misuse Service

10.1 Jayne Taylor and Amy Harmsworth introduced this item. Hackney and the City of London have been working in collaboration to review and draw up proposals regarding the recommissioning of the separate specialist drug and alcohol services currently in place across the borough and the corporation.

10.2 Jayne Taylor noted that this paper has been to Hackney Cabinet procurement Committee and the approach has been recognised as a good example of co-design work.

10.3 Amy Harmsworth noted that City and Hackney will be commissioning this service together. She noted that the benefits of doing this already have been realised within the current arrangement, whereby the same provider delivered the drug and alcohol treatment across the two local authorities.

10.4 Jake Ferguson noted that we need to ensure the right people are being targeted for this service. Amy responded and confirmed that a needs assessment was carried out within City & Hackney, with the evidence gathered, this will be used to ensure the right people are being supported.

10.5 Randall Anderson raised a concern about the City workers having access to this service. Amy confirmed that the City Workers could access brief advice and would be directed to services where they lived.

10.6 Jon Williams asked for a copy of the service specification.

10.7 The **City Integrated Commissioning Board**

- To **NOTE** work undertaken by Public Health officers to understand the local needs and requirements for a specialist drug and alcohol service, and the proposed focus of the new service as set out in the section entitled ‘proposals’ in the main report.

10.8 The **Hackney Integrated Commissioning Board**

- To **NOTE** work undertaken by Public Health officers to understand the local needs and requirements for a specialist drug and alcohol service, and the proposed focus of the new service as set out in the section entitled ‘proposals’ in the main report.

➢ **Jayne Taylor to share the service specification of the Adult Substance Misuse service with Jon Williams.**

11 Integrated Commissioning Progress report/Finance report

11.1 Ian Williams presented the finance report. He gave an update on the current position at month 4. He gave an overview of the local system spend. He proposed to bring a more detailed paper to a future meeting.

11.2 Sunil Thakker noted that the City & Hackney CCG is declaring a breakeven position. The reported position has been fully risk assessed with all known acute, non-acute and primary care risks and mitigations forming part of the forecast outturn for 2019/20.

11.3 Councillor Clark asked whether any forecasting and projections have been made on services for adults with learning disabilities. Ian Williams responded to say that there is work underway on this.

11.4 Anne Canning reassured ICB that there is a Transitional SEND group that meets with the Workstreams, this work is ongoing. Ann suggested that she would write a paper describing what this support looks like for City & Hackney.

- **Anne Canning to produce a paper on the Transitional SEND work and its interface with the workstreams.**

11.5 The **City Integrated Commissioning Board**

- **NOTED** the report.

11.6 The **Hackney Integrated Commissioning Board**

- **NOTED** the report.

12 Integrated Commissioning Workstreams Risk Registers

12.1 **The City Integrated Commissioning Board**

- **NOTED** the report.

12.2 **The Hackney Integrated Commissioning Board**

- **NOTED** the report.

13 S75 agreement between LBH, COL & CCG

13.1 **The City Integrated Commissioning Board**

- **NOTED** the report.

13.2 **The Hackney Integrated Commissioning Board**

- **NOTED** the report.

14. AOB & Reflections

14.1 Sunil Thakker noted that the audit being carried out on the overspend at Homerton will be completed by end of September 2019. The final report will go to the relevant committee meetings.

14.2 Marianne Frederick thanked Philip Glanville for all his support at the THRIVE event.

14.3 Councillor Clark noted that there was a great deal of positive work happening and that we need to be mindful of all the work underway within the local system.

14.4 David Maher shared his reflection on the opportunities within the local system and to be excited about the great work that is underway locally.

15. Integrated Commissioning Glossary

16. Date and time of next meeting

The next meeting will be held on 10 October, 10:00-12:00, Hackney Town Hall, Rom 102 & 103

City and Hackney Integrated Commissioning Programme Action Tracker

Ref No	Action	Assigned to	Assigned from	Assigned date	Due date	Status	Update
ICBJul-1	Immunisations risk to remain on the register and a **report on immunisations to be brought back to ICB in due course.**	Amy Wilkinson	City & Hackney Integrated Commissioning Board	11/07/2019	Nov-19	Open	
ICBJul-4	ICB would receive a further report on **workforce analysis by the CEPN team.**	Mark Rickets	City & Hackney Integrated Commissioning Board	11/07/2019	Nov-19	Closed	Has been agreed to estalish a workforce enabler of which CEPN will be a subset. Workshop to be held in November to which stakeholders will be invited.
ICBSep-1	Siobhan Harper to circulate the **final Better Care Fund paper** submitted to ICB members.	Siobhan Harper	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-2	Marianne Frederick to join the design group to refine the **Care Partnership logo** further.	Alice Beard	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-3	Ellie Ward to link up the **Branding Manager from the City** with Ben Knowles.	Ellie Ward	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-4	Nicholas Ib to update **page 66 of the long-term plan document to make reference to the VCS.**	Nicholas Ib	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-5	David Maher to confirm **STP timescales for engaging with the public** on the long-term plan**.**	David Maher	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-6	David Maher and Carol Beckford to ensure that ICB receive a copy of **City & Hackney's 2020/21 System Intentions for the October meeting.**	David Maher / Carol Beckford	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Closed	On the agenda
ICBSep-7	Jayne Taylor to share the **service specification of the Adult Substance Misuse service** with Jon Williams.	Jayne Taylor	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-8	Anne Canning to produce a paper on the **Transitional SEND work** and its interface with the workstreams.	Anne Canning	City & Hackney Integrated Commissioning Board	12/09/2019	Oct-19	Open	
ICBSep-9	An update on the **"Health, Care and Community Partners"** logo to be brought to the November ICB.	Alice Beard	City & Hackney Integrated Commissioning Board	12/09/2019	Nov-19	Open	

Title:	Integrated Commissioning Programme Progress Report
Date:	02 October 2019
Lead Officer/s:	Carol Beckford, Programme Director - Integrated Commissioning Carolyn Kus, Director of Programme Delivery
Author:	Stella Okonkwo, Programme Manager – Integrated Commissioning
Committee(s):	None.
Public / Non-public	Public

Executive Summary:

We have produced a progress report for the Integrated Commissioning (IC) Programme which covers the following areas:

- IC Programme/PMO
- Workstreams
- Enabler Groups
- System finance.

Progress is reported monthly to the Accountable Officers Group (AOG) and then on to the Integrated Commissioning Board (ICB). Progress report content forms the basis of our monthly updates to the East London Health & Care Partnership, the CCG Governing Body, and other ad hoc reports as required. Updates are collected from workstream and Enabler Group leads at the end of each month.

For the October ICB we have refreshed the report, so the information provided is, as at the 30th September 2019. It should be noted that we intend to change the reporting approach/template before the end of Q3 2019/20 so that it is more strategic, graphic in presentation and focuses on what the Workstream Directors and Enabler Group leads need to discuss with AOG and ICB. This means that there will be less focus on reporting steady state/green RAG status. The report will be more orientated to focus on the major transformation programmes which underpin the Long Term Plan, with a focus on, Neighbourhoods, Primary Care Networks and Community Services Development and the other major programmes which comprise the Integrated Health and Social Care agenda.

The current template covers:

- Progress on key activities in the previous month
- Planned activities for the coming month
- Progress against strategic milestones [as set by the ICB];
- Key risks and issues [these include all risks with a scope of 15+ from the ICB Risk Register and new risks provided by system leads as part of their monthly update];
- Any items which require a decision to be made by the AOG or the ICB.

Risk

We have included a summary of IC Risks and Issues in the Progress report – these will be pulled directly across from the IC Risk and Issues Register; this part of the document will be populated monthly by the IC Governance Manager. Enabler Groups are also required to send over risks relating to their portfolio areas monthly as part of their Progress report updates.

Milestones
We are reporting IC milestones forecasted for delivery from Q2 2019/20 to Q4 2019/20 from the IC 19/20 & 20/21 Roadmap.

Decisions for AOG and ICB
Any portfolio areas which require a decision from the AOG or the ICB will be required to provide a summary of what they need a decision on here in this section.

Finance
A finance update is provided by the IC Finance Team

Recommendations:

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

- To **NOTE** the October 2019 Integrated Commissioning Progress Report.

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

- To **NOTE** the October 2019 Integrated Commissioning Progress Report.

Strategic Objectives this paper supports:

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

Specific implications for City

The progress report summarises programmes of work which will impact City residents.

Specific implications for Hackney

The progress report summarises programmes of work which will impact Hackney residents.

Patient and Public Involvement and Impact:

All programmes of work referenced in the Progress report will impact patients and members of the public in the future, many of these programmes of work will have:

- their own programmes of resident consultation planned, and

- will feed into governance arrangements which will involve patient and public representatives

Clinical/practitioner input and engagement:

All programmes of work referenced in the Progress report relate to programmes of work which will feed into parts of the IC governance system which involve clinicians

Equalities implications and impact on priority groups:

Some of the Programmes of work referenced in the Progress report will impact specific priority groups, for example: young parents, young people and mental health

Safeguarding implications:

All Programmes of work referenced in the Progress report will interface appropriately with safeguarding governance and assurance across the City and Hackney system

Impact on / Overlap with Existing Services:

N/A

Supporting Papers and Evidence:

October 2019 Integrated Commissioning Progress Report

Sign-off:

London Borough of Hackney: Anne Canning

City of London Corporation: Andrew Carter

City & Hackney CCG: David Maher

C&H Integrated Commissioning and Care Programme – Monthly IC progress report

For the Integrated Commissioning Board & Accountable Officers Group

Overall progress

- The City & Hackney response to the Long-Term Plan (LTP) was presented and discussed with 11 Boards/Committees across the system during September 2019. Final updates were made to the document before it was submitted to NEL to enable their team to complete the STP NEL LTP and submit it to NSH England on time at the end of September.
- The 2020/21 System Intentions were signed off by the CCG Governing Body following sign-off from boards and stakeholders who are party to the delivery of what has been set out in the System Intentions. Work now starts on agreeing relevant contract changes.
- After endorsement from the development sessions of the ICB and Governing Body meetings in September, the CCG, through the Community Services Development Board, is implementing an application process for the Neighbourhood Health and Care Services Alliance with the Homerton Hospital, ELFT and City and Hackney's GP Confederation. This process will be overseen by a NHCS Oversight Group, reporting to CCG Governing Body.

1. Key activities in September 2019

Workstream	Activity	Status
IC Programme PMO	• Ongoing review of Enabler Groups work programmes: current focus is on IT Enabler, Estates Enabler and CPEN Enabler becoming a Workforce Enabler • Deep-dive workshop held with ICB Risk Champion, Workstream Directors, Enabler Leads and other Programme Directors to undertake a fundamental refresh the AOG/ICB Risk Register (1 Oct). The refreshed risk register will be available for the November 2019 ICB • Work has started on scoping the work to be done to prepare for April 2021: One ICS, One CCG: Leadership Summit discussion and the establishment of CCG 2021 Oversight Group. • New IC Programme Director – Dr Carolyn Kus started on the 9th of September. Handover from interim IC Programme Director commenced.	Green
	• Ongoing development of the IC programme plan: This is amber because more work needs be done to secure Workstream Director consensus to what we needs to be reported at a *strategic level* to AOG and ICB along with the format of the presentation to replace this monthly progress report. The get to green strategy: we are going to develop an exemplar using just Planned Care to ensure that we have signoff to the approach before rolling out to all Workstreams and Enablers	Amber
Prevention CW	• Making Every Contact Count (MECC): training provider contract awarded; scoping report produced; logic model/evaluation framework and comms/engagement plan agreed. • Social Prescribing: continued engagement with, and support to, PCNs to recruit funded link workers; finalised planning of formal engagement to inform re-design of commissioned service; commenced testing of Digital Social Prescribing Platform (DSPP). • Directory of Services: testing of minimum viable product; system review meeting to agree next steps. • Community navigation (joint Neighbourhoods project, CEPN funded): New programme manager to take forward initial planning/mapping work (successfully recruited in August). • Prevention Investment Standard: Discussion paper taken to AOG. • City and Hackney adult substance service: business case approved; EOI notice published..	Green
Planned Care CW	• Submission of System Intentions Plans for Planned Care • Outpatient Transformation Task and Finish groups continue to develop improvement plans for Homerton specialities, further work on future model for LTC is under discussion in line with Neighbourhood Health and Care services • Continued development of the INEL CHC Transformation Review Implementation Plan • Submission of the Contract Award Report for the Housing First service • Big Do celebration event for LD service users and carers • Continued emphasis on establishment of joint funding processes for LD service users.	Green
Unplanned Care CW	• Implementation of recommendations from Discharge to Assess Pilot • Updated INEL Urgent programme plans (incorporating feedback from INEL Steering Group) will be presented to the INEL System Transformation Boards • A workshop set up in September to introduce the PCN Clinical Directors to providers and leaders across the system and look at OD requirements • Ongoing work with system partners to design the neighbourhood based anticipatory care service • 'The Perfect Day' (integration of 111 & 999 in order to use all parts of the system to reduce ambulance conveyances to hospital) pilot held on 30 September	Green
CYPMF CW	• Prepare for 'Go live' (October) of mental health support teams in schools (as part of national trailblazer programme). Continued work on CAMHS transformation refresh. • Implementation of new emotional wellbeing offer for Black African & Caribbean Heritage young people (up to 25years) to begin, in partnership with the VCS, following successful national funding bid (EMBARGOED). • New Health of Looked After Children's service delivered by HUFT – Go live 01 Sep, New strategy to address Adverse Childhood Events to start drafting, following on from July workshop, • Work continuing to develop CYP integrated & pooled speech and language service from April 2020 • Implementation of new local and WEL Safeguarding arrangements from 29 September • Developing Primary care families work in line with PCNs, neighbourhood immunisations and paediatric psych liaison pilots • Early work to develop local protocols around children's LD / Autism and CETRs progressing.	Green

2. Key activities planned for October 2019

Workstream	Activity	Status
IC Programme PMO	• ICB Development Session on the governance arrangements to be put in place for an Integrated Care Board within City & Hackney as we move towards a One ICS and One CCG within NEL • Sign-off of the draft 2020/21 System Intentions by the ICB and document shared widely across organisations and partners, the ODG and Clinical Commissioning Forum (CCF) • Commence the work required to establish an IC Workforce Enabler which encompasses CEPN • Ongoing development of the IC programme plan with a focus on Planned Care • Handover to New Programme Director	**Green**
Prevention CW	• MECC: Develop action plan to implement recommendations from scoping phase; mobilise training contract; update to October Prevention Core Leadership Group. • City and Hackney Substance Misuse Service: ITT published. • Supported Employment Network: network meeting to take forward programme plans. • Social Prescribing: Stakeholder engagement to inform design of new commissioned service commences. • Directory of Services: Business case for next stage development. • Prevention Investment Standard: Discussion paper being taken to ICB; mobilisation plan to be developed and initiated.	Green
Planned Care CW	• Gastroenterology, ENT and Rheumatology will commence as part of Wave 3 of the Outpatient Transformation programme. Hypertension will complete with the agreement of updated pathways and operating processes. • Ongoing recruitment of Outpatients Transformation Manager and IT Project Manager • Housing First Contract Award Report to be submitted (rescheduled from September) • Updated Learning Disability Strategy and funding plan to be agreed-workshop taking place to resolve any issues • Continuing Healthcare External Review Report available • Audit to confirm figures for number of Personal Health Budgets completed	Green
Unplanned Care CW	• Roll-out of End of Life Rapid Response overnight service pilot as a shared service with Newham CCG, provided by Marie Curie. • Implementation of recommendations from Discharge to Assess Pilot • Support to PCN Clinical Directors to meet system leaders and establish their place in the system.	Green
CYPMF CW	• Continued implementation of new mental health support teams in schools, CAMHS transformation refresh, and new emotional wellbeing offer for Black African & Caribbean Heritage YP (Partnership with VCS, successful national funding bid) • First London-wide Clinical Governance and Leadership Board to implement CYP national transformation (LTP) takes place 15th October. C&H secured place on Board. • Logic model for C&H ACEs approach in place. Drafting of strategy to commence. • 100% of maternity bookings now on Personalised Care Plans (PCP). New digital lead in place for WS from Nov, to implement new digital platform to improve women's experience. Design to start. • Build recs from Sept workshop into design of integrated CYP SLT service (live 2020) • Local and WEL Safeguarding arrangements operational from 29 September. CDOP arrangements to be agreed. • Continued early work on families work in line with PCNs. Paediatric Psychiatric liaison pilot agreed for Woodberry Wetlands.	Green

C&H Integrated Commissioning and Care Programme – Monthly IC progress report

For the Integrated Commissioning Board & Accountable Officers Group

1. Key activities in September 2019 (cont.)

Enabler Group	Activity	Status
Communications & Engagement Enabler	• ICCEEG to implement Co-Production Self-Assessment tool with Workstream and service user input. On- going (Due October) • Primary Care Strategy – ICCEEG Lead to assist with plans to meaningfully involve patients and residents in the updates primary care strategy. • Reward and Recognition Policy - to be completed, with implementation of payment procedure expected by end of September	Green
	• Whilst the ICB signed off the IC Brand strapline, the logo was not signed off	Red
Primary Care Enabler	• Finalise PCN seasonal flu improvement plan • Continue dispersal of Abney practice • Further primary care strategy coproduction work – detail TBC by Co-production Steering Group • Detailed review to CEC (11/8/19) and FPC (18/8/19) and report to AOG (17/8/19) • Sign off of NEL Primary Care Strategy at CCG GB 27/8/19 • First meeting of NEL Primary Care Commissioning Committees in common (1/10/19) • Continue migration from existing N3 connections to new secure Health and Social Care Network compliant connections for all GP practices	Green
Estates Enabler	• STP partners are currently in the process of updating the Estates strategy. The CCG is also in the process of reviewing and updating its estate strategy to ensure it reflects the NHS LTP (Long Term Plan). • The first Capital Projects Board meeting (in relation to proposed LBH developments for primary care) was held on the 23rd September. The Capital Projects procurement is due for sign off shortly and will enable the appointment of a Project Manager for the two developments at Belfast Road (for Springhill Practice) and The Portico (For Lower Clapton Health Centre). • St Leonards site tender had three organisations for interview and Attain were selected as the preferred bidder and they have started work with a proposed final report in February 2020. • A Property Database is being collated to provide a record of both available properties for occupation and any requirements by the group members so that demand and supply can be readily matched.	Green
IT Enabler	• T-Quest for orders & results - Review funding/resource commitment	Amber
	• Discharge to Pharmacy project review. Revise delivery plan (upgrade required)	Amber
	• Skype for Diabetes options appraisal. Review NHS Digital pilot offer	Red
	• East London Patient Record (HIE) – social care data sharing (LBH): Continue further tests to ensure readiness for go-live	Green
	• Directory of Services development – Minimum viable product (MVP) being developed as proof of concept that the data flows required to keep it up to date are possible	Green
	• Population Health for Neighbourhoods Options Appraisal	Green
	• Digital Social Prescribing – procure system; agree scope for stage 1	Green
	• Review and re-prioritise projects to support LTP/care work stream aims	Green
CEPN Enabler	• Continued recruitment drive for HEE Fellows • Co-ordination of Clinical Practitioner Forum (3rd of 4), re-arranged due to date conflict with CDs/CCG meeting • Work with NEL, HEE and C&H key stakeholders to produce the resource pack for Health and Social Care Careers Fair in November 19 and supporting wider recruitment across the system • Promotion of CEPN/Training Hub website • Planning and co-ordination of Simulation Training with HUH • Planning of the Out of Hospital Nursing Conference (November 19) • Creation of portfolio nursing roles across PC, community, social care and MH	Green

2. Key activities planned for October 2019 (cont.)

Enabler Group	Activity	Status
Communications & Engagement Enabler	• Next ICCEEG Meeting - Weds 2nd October & Weds 9th October • ICCEEG to implement Co-Production Self-Assessment tool with workstream and service user input. On- going (Due October) • Review of Co-production Charter. • Review of IC Brand and logo - Follow-up actions to take place in order to establish new brand / logo.	Green
Primary Care Enabler	• Monitor PCN seasonal flu improvement plan • Continue dispersal of Abney practice • Further primary care strategy coproduction work – first draft 10/10/19 • Next meeting of Primary Care Enabler Board 10/10/19 – expecting proposals on setting up a volunteers in primary scare pilot (in line with LTP commitment) • Continue migration from existing N3 connections to new secure Health and Social Care Network compliant connections for all GP practices • Local Primary Care Commissioning committee 25/10/19	Green
Estates Enabler	• STP partners are in the process of updating the Estates strategy. The CCG is also in the process of reviewing and updating its estate strategy to ensure it reflects the NHS LTP (Long Term Plan) - There is no timeline yet on when the STP update will be ready however the CCG are currently preparing a draft update, which should be ready in November. • LBH will be seeking to tender for the Project Manager for the Capital Projects • Attain to provide and agree the PID for the St Leonards site • All Estates Enabler members to provide details of both availability of space and requirements to LBH who will maintain the data and make it available to all members	Green
IT Enabler	• T-Quest for orders & results – Clarify EMIS quotation, Schedule work	Amber
	• TCAMS (Discharge to Pharm)- Integration engine upgrade, design patient workflow	Amber
	• Skype for Diabetes options appraisal - Seek to close; Convert to Attend Anywhere pilot	Amber
	• East London Patient Record (HIE) – social care data sharing (LBH): Continue further tests to ensure readiness for go-live	Green
	• Directory of Services development – Developing proof of concept that the data flows required to keep it up to date are possible	Green
	• Digital Social Prescribing – procure system; agree scope for stage 1	Green
	• Review and re-prioritise projects to support LTP/care work stream aims	Green
CEPN Enabler	• Re-advertisement for HEE Fellows/SPIN programme • Secure date/planning for MH Clinical Practitioner Forum • Progress engagement and planning for Health and Social Care Careers Fair in November 19 and supporting wider recruitment across the system • Planning of Out of Hospital Nursing Conference - Date of Out of Hospital Nursing Conference moved to 5th December, • Compile handover and legacy report as Interim Lead leaving post 12th November	Green

C&H Integrated Commissioning and Care Programme – Monthly IC progress report

For the Integrated Commissioning Board & Accountable Officers Group (Page subject to review along with programme plan)

3. Delivery of and change to any key ICB Milestones Q1-4 2019/20

Milestone	Target	Forecast	Status
IC Programme: New governance for aligned Neighbourhood Programme and Neighbourhoods Health and Care in place, Long Term Plan (LTP) engagement plan agreed – moved from Q1 to Q2 as guidance has been released.	Q1 2019/20	Q2 2019/20	Completed
IC Programme: Agree the following: local submission for LTP, Comms and Engagement Strategy & IC Strapline signed by the ICB, produce summary of feedback of engagement on LTP & agreed actions	Q2 2019/20	Q2 2019/20	Completed
Unplanned Care: Evaluation of discharge to assess pilot	Q2 2019/20	Q2 2019/20	Completed
CYPMF: the following to go live: New Community Nursing Model goes live, Looked After Children (LAC) service, CAMHS mental health and wellbeing program wider roll-out to schools	Q2 2019/20	Q2 2019/20	Completed
Planned Care: Development of a proposed Alliance model for the neighbourhood programme.	Q2 2019/20	Q2 2019/20	On Track
IC Programme: ICB meets in partnership with providers, system medium term Financial Plan developed, agree new financial risk sharing arrangements, agree model for population risk stratification, map primary care workforce profile, deliver City & Hackney linked data sets	Q3 2019/20	Q3 2019/20	On Track
Planned Care: amend/update POLCE policy as per engagement outcomes & formally agree policy, evaluate the housing tender for the jointly commissioned Housing First Service, Complete Evidence Based Interventions Policy (PoLCE) engagement & agree monitoring arrangements with Providers /CSU	Q3 2019/20	Q3 2019/20	On Track
Unplanned Care: the following to go live: New Discharge Model, new Urgent End of Life Care Model, evaluate the housing tender for the jointly commissioned Housing First Service; Conclusion of duty doctor service review,	Q3 2019/20	Q3 2019/20	On Track
CYPMF: Implementation of City & Hackney approach to Adverse Childhood Events, costed Learning Disability Strategy approved & implementation to begin, Children & Families Neighbourhood partnership project work to begin	Q3 2019/20	Q3 2019/20	On Track
Prevention: City Alcohol Strategy to be published, Hackney Carers Service live	Q3 2019/20	Q3 2019/20	On Track
CEPN: Work with NEL to: develop Workforce Development Tools, C&H to host NEL-wide funding for recruitment and training of TNA Educator posts, work with NEL to secure funding to develop and deliver Leadership Programme across PCN Directors	Q3 2019/20	Q3 2019/20	On Track
CEPN: Begin work to map Primary Care Workforce Profile & begin to establish a database of vacancies. Creation of and recruitment to HEE Fellows across Primary and Specialist Care	Q3 2019/20	Q3 2019/20	On Track
CEPN: Lead and Project manage deliver of Health and Social care careers fair.	Q3 2019/20	Q3 2019/20	On Track
IC Programme: Governance agreed for C&H Commissioner and Provider Board, review strategic IC Safeguarding Approach, New Neighbourhoods H&SC contracting arrangements in place, develop a financial model for Community Services to support identification of system efficiencies, IC logo signed by ICB and subsequent public engagement	Q4 2019/20	Q4 2019/20	On Track
Planned Care: Implement POLCE Policy, sign off new Housing First Service at ICB, the following to go live: Mental Health Accommodation High Needs Pathway, CHC service	Q4 2019/20	Q4 2019/20	On Track
Unplanned Care: Delivery of IC Winter Plan	Q4 2019/20	Q4 2019/20	On Track
Neighbourhoods: Neighbourhood Programme to go live, Neighbourhood pilots for adult community nursing, mental health and adult social care to be evaluated and agreed roll out plan	Q4 2019/20	Q4 2019/20	On Track
CEPN: Carry out a needs analysis for workforce enablement across the system; Host Mental Health Clinical Practitioner Forum; Board recognition and agreement of National and local CEPN Priorities	Q4 2019/20	Q4 2019/20	On Track
CEPN: Primary Care placement database to go live; Secure funding to ensure Sustainability of C&H Training Hub for workforce development	Q4 2019/20	Q4 2019/20	On Track

C&H Integrated Commissioning and Care Programme – Monthly IC progress report

For the Integrated Commissioning Board & Accountable Officers Group

4. Key issues and risks

Workstream / Enabler Group	Description	New or existing	Rating
IC Programme PMO	• Insufficiently robust framework of risk management provided by ICB to statutory bodies. • System SEND overspend. • Enabler group strategic agendas not clear to ICB or AOG. • NEL Long-Term Plan may arrive too late for adequate engagement. • Scope & focus of CEPN is unclear – roles & responsibilities in relation to workforce need better communication.		• 16 • 20 • 16 • 16 • 16
Prevention CW	• Failure to address complex commissioning landscape for health services supporting rough sleepers in the City of London.		• 20
Planned Care CW	• Financial pressures in the Adult Learning Disability Service. • Risk of over-performance on elective activity.		• 20 • 20
Unplanned Care CW	• Difficulties in recruiting GP staff. • Discharge and Hospital Flow processes are not effective, resulting in increased DToCs and failure to meet Length of Stay Targets. • Lack of visibility of social care funding beyond 2019/20. • New ways of working in Neighbourhoods may require information to be shared across providers in ways not covered by existing information and sharing protocols.	• Existing • New	• 16 • 20 • 16 • 16
CYPMH CW	• Continuing to monitor risk around low uptake of immunisations in some areas of Hackney. • Emerging risk around implementation of new WEL child death overview panel arrangements.	• Existing • New	10
Engagement and Comms Enb	• No risks to escalate.		
Primary Care Enb	• No risks to escalate.		
Estates Enb	• New Dept of Health policy on 'Transfer of NHS PS and CHP assets to NHS and Foundation Trusts' • Ongoing invoice disputes yet to be resolved by NHS PS and CHP (these are also being addressed at an STP level)		
IT Enb	• T-Quest/ EMIS Proxy Server Migration • Discharge to Pharmacy project review • Skype for Diabetes options appraisal		
CEPN	• Lack of capacity is high risk due to staffing levels.		

5. Finance Update (£'000)

	Organisation	Annual Budget	Forecast Outturn	Forecast Variance	YTD Budget	YTD Spend	YTD Variance	RAG
Pooled Budgets	City and Hackney CCG	£25,614	£25,614	-	£10,673	£10,673	-	
	London Borough of Hackney Council	*LBH split between pooled and aligned not available.						
	City of London Corporation	£210	£210	-	£52	£30	22	
Total		**£25,824**	**£25,824**	**£0**	**£10,725**	**£10,703**	**£22**	
Aligned Budgets	City and Hackney CCG	£402,599	£402,599	-	£161,160	£161,160	-	
	London Borough of Hackney Council	*LBH split between pooled and aligned not available.						
	City of London Corporation	£7,641	£7,327	314	£2,729	£2,595	134	
Total		**£410,240**	**£409,926**	**£314**	**£163,889**	**£163,755**	**£134**	
ICF	City and Hackney CCG	£428,213	£428,213	-	£171,833	£171,833	-	
	London Borough of Hackney Council	£103,373	£106,617	(3,244)	£43,072	£52,324	(9,252)	
	City of London Corporation	£7,851	£7,537	314	£2,781	£2,625	156	
Total ICF Budgets		**£539,437**	**£542,367**	**-£2,930**	**£217,686**	**£226,782**	**-£9,096**	
CCG Primary Care co-commissioning		£48,081	£48,081	-	£17,614	£17,614	-	
Total		**£48,081**	**£48,081**	**£0**	**£17,614**	**£17,614**	**£0**	

6. Decisions required by the ICB / For attention of the AOG

Programme Area	Decision required
Integrated Learning and Disability Service	• Approval of S75 Arrangements
Mental Health	• Approval of MH Strategy

Title:	Integrated Commissioning Register of Escalated Risks
Date of meeting:	10 October 2019
Lead Officer:	Carol Beckford, Integrated Commissioning Programme Director
Author:	Alex Harris, Integrated Commissioning Governance Manager
Committee(s):	Integrated Commissioning Board, 10 October 2019
Public / Non-public	Public.

Executive Summary:

This report presents a summary of risks escalated from the four care workstreams and from the Integrated Commissioning programme as a whole.

Background

The threshold for escalation of risks is for the residual risk score (after mitigating action) to be 15 or higher (and therefore RAG-rated as red). The ICB also receives the full workstream risk registers on a quarterly basis, and may request that risks which do not meet the escalation criteria outlined above still nonetheless be reported on the ICB register of escalated risks.

Each of the four Care Workstreams has responsibility for the identification and management of risks within its remit. All risks identified are associated with a particular area of work, be it a care workstream, a cross-cutting area such as mental health, or the overall Integrated Commissioning Programme.

Risks added since September

The full Integrated Commissioning Workstream risk registers were shared with the ICB at the September meeting. There has been no change in escalated risks since that meeting, however the risk UPC16 is proposed to be categorised as a programme-level risk as it does not arise from (and cannot be mitigated by) the workstream.

Recommendations:

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

- To **NOTE** the report.

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

- To **NOTE** the report.

Strategic Objectives this paper supports:

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

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Supporting Papers and Evidence:

Appendix 1 - Integrated Commissioning Escalated Risk Register – October 2019

Sign-off:

Siobhan Harper – Director: Unplanned Care

Amy Wilkinson – Director: Children, Maternity, Young People and Families

Nina Griffith – Director: Planned Care

Jayne Taylor – Director: Prevention

Carol Beckford – Interim Director: Integrated Commissioning

Integrated Commissioning Register of Escalated Risks - October 2019

Ref#	Description	Risk owner	Likelihood	Impact	Current Score	Residual Risk Score Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Mitigating actions
IC2	**Issue - System SEND Overspend** At the meeting on 21 January 2019 workstream noted that there is a significant financial risk to partners relating to SEND Overspend, and there is no local mitigation, since it is a question of structural resources. It was agreed that the risk should be red-rated for escalation to the Integrated Commissioning Board.	Anne Canning	5	3	15	20	15			This issue was highlighted by the CYPMF Workstream but it is a system-wide issue and the workstream recommends this should be held at the programme level. Given that the risk is system-wide rather than workstream level, it is also recommended that the severity level should be rated at moderate, rather than severe (based on the scoring guidelines). It has also been agreed that this will be considered an Integrated Commissioning Programme Risk as opposed to a solely CYPMF workstream risk as the issue is system-wide.
P13	**Priority area: Rough Sleepers** Failure to address complex commissioning landscape for health services supporting rough sleepers in the City of London means that significant health and care needs remain within this community	Jayne Taylor	4	5	20	20	20	16		A discussion paper was presented to the Prevention CLG in August and the intention is for proposals to be developed and presented to ICB later this year. Work is underway at the INEL System Transformation Board to ensure that the health needs of rough sleepers are incorporated into the STP's NHS Long Term Plan submission. Additional capacity is being secured to scope out an action plan.
PC1	**Adult Learning Disability Service** There are significant financial pressures in the Adult Learning Disability service which require a sustainable solution from system partners	Siobhan Harper	4	5	20	20	20			Joint funding arrangements will now be formally implemented and this will enable a consistent approach to additional health funding for individual care packages where a health need is identified. Further financial planning to support the implementation of the agreed strategy for people with Learning Disabilities will also support a move to community asset based model of service rather than more traditional models of care. The impact of SEND and transition also needs to be carefully modelled for future years.
PC2	**Overperformance on elective activity** There remains a risk of overperformance on elective activity with our main provider and with other acute providers which is beyond our risk tolerance	Siobhan Harper	4	5	20	20	20	15		Relationships with our main provider are strong and continue to develop through shared mitigation plans by auditing and understanding demand and activity flows and the management of RTT and patient waiting lists. We are also exploring new payment mechanisms to contain risk. Our Outpatient Transformation programme is also being reviewed and refreshed and we expect to be increasingly assured of our risk mitigation by the end of Q2.
UPC9	**Discharge and Hospital Flow Processes** Discharge and Hospital Flow processes are not effective, resulting in increased DToCs and failure to meet Length of Stay Targets	Nina Griffith	5	3	15	12	15			Weekly teleconference continues although DTOC targets were not met for Q1. HICM group are implementing DTOC case review action plan. The group is also considering whether a MADE event would be of benefit. Evaluation of Discharge 2 Assess pilot has been completed.
UPC15	**GP Staff Recruitment** Ongoing difficulties in recruiting GP staff across unplanned care services, including OOH, PUCC and Primary Care puts pressure on the whole C&H health system - risk that patients aer thus seen in acute settings such as A&E, with impact on HUH 4 hour target and cost	Nina Griffith	4	4	16	16	16			Benchmarking of GP rates of pay undertaken in collaboration with TH CCG The Workstream SRO sits on the the NEL Workstream Advisory Board (WAB), which is currently discussing how to manage the recruitment issues across the whole STP footprint.
UPC16	**Social Care Funding** There is a lack of visibility of social care funding beyond 2019/20. This makes it difficult to plan ahead as a system, and risks possible impacts on the whole system if there is any future short-fall in social care budgets.	Nina Griffith	4	4	16					This is a system risk rather than a risk that sits within the Unplanned Care Workstream. **We therefore recommend that the Unplanned Care Board should escalate the risk to the Integrated Commissioning Board.**

						Residual Risk Score				
Ref#	Description	Risk owner	Likelihood	Impact	Current Score	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Mitigating actions
CYPMF1	**Childhood Immunisations** Risk that low levels of childhood immunisations in the Borough may lead to outbreaks of preventable disease that can severely impact large numbers of the population	Amy Wilkinson	2	5	10	15	10			Following a CCG-funded outbreak response across partner organisations, the Measles outbreak is now over and there were no fatalities. A 2- year action plan for ongoing action to maintain low levels is in its final draft stage. We have good relationships with stakeholders and are working closely with NHSE via the Immunisations Steering Group. Two Public Health Communicaitons campaigns have gone well and there is a long term plan to mitigate ongoing risks, with pilot activity in the north of the borough being run through the Neighbourhoods. An update report will be taken to the ICB in November 2019.

Title of report:	Consolidated Finance (income & expenditure) 2019/2020 - Month 5
Date of meeting:	10/10/19
Lead Officer:	Anne Canning, London Borough of Hackney (LBH) Jane Milligan, City & Hackney Clinical Commissioning Group (CCG) Simon Cribbens, City of London Corporation (CoLC)
Author:	Integrated Commissioning Finance Economy Group: Sunil Thakker, Director of Finance, City & Hackney CCG Mark Jarvis, Head of Finance, Citizens' Services, City of London Ian Williams, Group Director, Finance and Corporate Resources, LBH
Committee(s):	City Integrated Commissioning Board Hackney Integrated Commissioning Board Transformation Board
Public / Non-public	Public

Executive Summary:

At Month 5 the Integrated Commissioning Fund has an adverse year end forecast variance of £2.9m.

City & Hackney CCG is declaring a breakeven position. The reported position has been fully risk assessed with all known acute, non-acute and primary care risks and mitigations forming part of the forecast outturn for 2019/20.

The London Borough of Hackney is reporting a year-end adverse position of £3.2m. The position is driven by cost pressures on Learning Disabilities budgets (primarily commissioned care packages) and challenges around Housing Related Support (HRS) service redesign.

The City of London is reporting a year-end favourable position of £0.3m mainly driven from older people residential care.

Recommendations:

The City Integrated Commissioning Board is asked:

- To **NOTE** the report.

The Hackney Integrated Commissioning Board is asked:

- To **NOTE** the report.

Strategic Objectives this paper supports:

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☐	

Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☐	
Ensure we maintain financial balance as a system and achieve our financial plans	☒	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☐	
Empower patients and residents	☐	

Specific implications for City

N/A

Specific implications for Hackney

N/A

Patient and Public Involvement and Impact:

N/A

Clinical/practitioner input and engagement:

N/A

Equalities implications and impact on priority groups:

N/A

Safeguarding implications:

N/A

Impact on / Overlap with Existing Services:

N/A

Sign-off:

London Borough of Hackney: Ian Williams, Group Director of Finance and Corporate Resources

City of London Corporation: Mark Jarvis, Head of Finance

City & Hackney CCG: Sunil Thakker, Director of Finance

City of London Corporation
London Borough of Hackney
City and Hackney CCG

Integrated Commissioning Fund
Financial Performance Report

Month 05 - 2019/20

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Consolidated summary of Integrated Commissioning Budgets

	Organisation	Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Outturn Forecast Outturn £000's	Forecast Outturn Forecast Variance £000's	Forecast Outturn Prior Mth Variance £000's
Pooled Budgets	City and Hackney CCG	25,614	10,673	10,673	-	25,614	-	-
	London Borough of Hackney Council	*LBH split between pooled and aligned not available.						
	City of London Corporation	210	52	30	22	210	-	-
Total		25,824	10,725	10,703	22	25,824	-	-
Aligned	City and Hackney CCG	402,599	161,159	161,160	(0)	402,599	-	-
	London Borough of Hackney Council	*LBH split between pooled and aligned not available.						
	City of London Corporation	7,641	2,729	2,595	133	7,327	314	222
Total		410,240	163,888	163,755	133	409,925	314	222
ICF	City and Hackney CCG	428,213	171,832	171,832	(0)	428,213	-	-
	London Borough of Hackney Council	103,373	43,072	52,324	(9,252)	106,617	(3,244)	(3,241)
	City of London Corporation	7,851	2,781	2,625	156	7,537	314	222
Total ICF Budgets		**539,437**	**217,685**	**226,782**	**(9,097)**	**542,367**	**(2,930)**	**(3,019)**
CCG Primary Care co-commissioning		48,081	17,614	17,614	-	48,081	-	-
Total		**48,081**	**17,614**	**17,614**	**-**	**48,081**	**-**	**-**

Page 36

Notes:

- Unfavourable variances are shown as negative. They are denoted in brackets & red font
- ICF = Integrated Commissioning Fund – comprises of Pooled and Aligned budgets
- ***Pooled and aligned funds are not split as for the most part pooled funds do not meet the cost of whole discrete services and therefore the split would not be representing the true position.**

Summary position at Month 05

- At Month 5 the Integrated Commissioning Fund has an adverse year end forecast variance of £2.9m.
- City & Hackney CCG is declaring a breakeven position. The reported position has been fully risk assessed with all known acute, non-acute and primary care risks and mitigations forming part of the forecast outturn for 2019/20.
- The London Borough of Hackney is reporting a year-end adverse position of £3.2m. The position is driven by cost pressures on Learning Disabilities budgets (primarily commissioned care packages) and challenges around Housing Related Support (HRS) service redesign.
- The City of London is reporting a year-end favourable position of £0.3m mainly driven from older people residential care.
- **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (BCF) including the Integrated Independence Team (IIT) and Learning Disabilities.

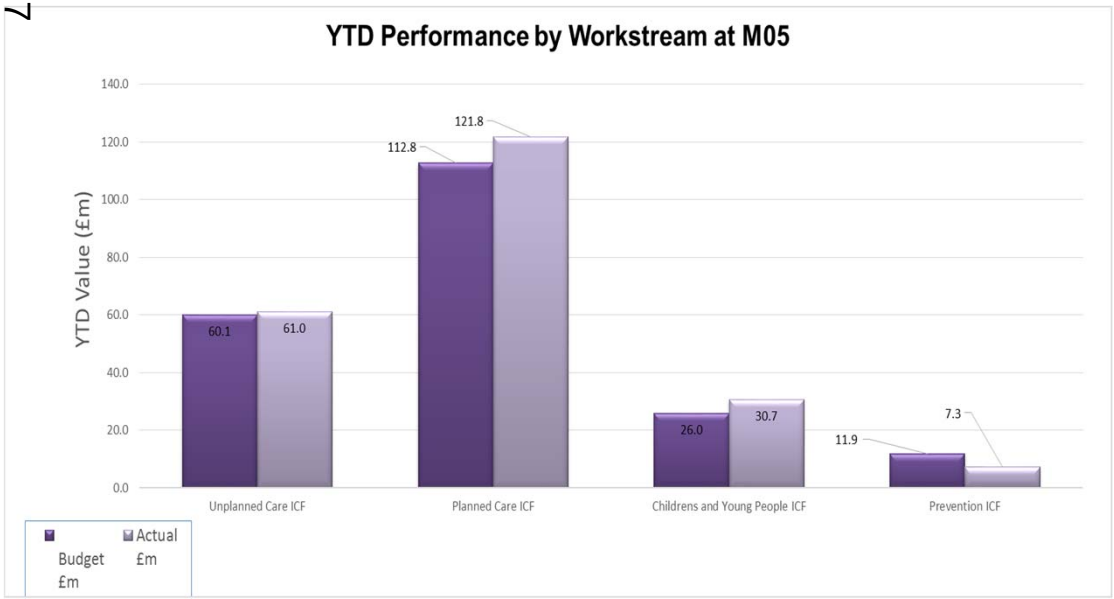
Note

Planned Care further pooling of Continuing Healthcare (CHC) and Adult Social Care budgets are expected to be actioned this financial year .

***Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.**

Integrated Commissioning Budgets – Performance by workstream

		YTD Performance			Forecast Outturn	
WORKSTREAM	Annual Budget £m	Budget £m	Actual £m	Variance £m	Forecast Outturn £m	Forecast Variance £m
Unplanned Care ICF	144.8	60.1	61.0	(0.9)	145.1	(0.3)
Planned Care ICF	275.7	112.8	121.8	(9.0)	280.1	(4.5)
Childrens and Young People ICF	63.1	26.0	30.7	(4.7)	63.1	0.0
Prevention ICF	28.9	11.9	7.3	4.6	28.9	0.0
All workstreams	**512.4**	**210.8**	**220.8**	**(10.0)**	**517.2**	**(4.8)**
Corporate services	25.6	6.3	5.6	0.7	23.8	1.9
Local Authorities (DFG Capital and CoL income)	1.3	0.6	0.4	0.2	1.4	(0.0)
Not attributed to Workstreams	**27.0**	**6.9**	**6.0**	**0.9**	**25.1**	**1.9**
Grand Total	**539.4**	**217.7**	**226.8**	**(9.1)**	**542.4**	**(2.9)**



Performance by Workstream.

- The report by workstream combines 'Pooled' and 'Aligned' services but excludes chargeable income. CCG corporate services are also excluded and are shown separately as they do not sit within workstreams.
- The workstream position reflects the Integrated Commissioning Fund without the application of mitigating reserve and corporate running costs.
- **Planned Care:** The £4.5m adverse position is driving the consolidated forecast. This is due to the London Borough of Hackney;
  - Learning Disabilities Commissioned care packages, although much reduced from the 2018/19 position due to the application of both budget growth and one-off funds, is reporting £1m adverse against year end budget.
  - Physical & Sensory Support is forecasting an overspend of £0.5m.
  - Memory/Cognition & Mental Health ASC (OP) is forecasting an overspend of £0.6m.
  - The Mental Health service provided in partnership with the East London Foundation Trust (ELFT) within this work stream is forecast to overspend by £0.5m.
  - Ongoing challenges around Housing Related Support (HRS) service redesign is resulting in a £0.8m overspend.
  - In addition, the Barts acute contract within the CCG is forecast to over spend by £0.7m.
- **Unplanned Care:** At month the workstream is forecasting an under spend of £0.3m. This is being driven by the CCG where over performance on the Bart's contract (£0.8m) is being offset by the LBH where Interim Care is underspending - £0.5m - due to overspends on care packages.

*Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

City and Hackney CCG – Position Summary at Month 05, 2019/20

				YTD Performance			Forecast		
	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Commissioned	Unplanned Care	18,503	7,710	7,710	0	18,503	0	0
		Planned Care	7,060	2,942	2,942	0	7,060	0	0
		Prevention	51	21	21	0	51	0	0
		Childrens and Young People	0	0	0	0	0	0	0
	Pooled Budgets Grand total		25,614	10,673	10,673	0	25,614	0	0

	ORG	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Forecast Outturn £000's	Forecast Variance £000's	Prior Mth Variance £000's
Aligned	Commissioned	Unplanned Care	120,600	50,152	50,537	(385)	121,428	(829)	(728)
		Planned Care	200,015	81,303	81,624	(322)	201,073	(1,058)	(1,051)
		Prevention	3,826	1,594	1,594	0	3,826	0	0
		Childrens and Young People	52,510	21,783	21,776	7	52,503	8	(62)
		Corporate and Reserves	25,648	6,328	5,628	699	23,769	1,879	1,841
	Aligned Budgets Grand total		402,599	161,159	161,160	(0)	402,599	0	0
Subtotal of Pooled and Aligned			**428,213**	**171,832**	**171,832**	**(0)**	**428,213**	**0**	**0**

In Collab	Primary Care Co-commissioning		48,081	17,614	17,614	0	48,081	0	0
Grand Total			**476,294**	**189,446**	**189,447**	**(0)**	**476,294**	**0**	**0**
CCG Total Resource Limit			**506,712**						
SURPLUS			**30,418**						

- **Primary Care Co-Commissioning (outside of the ICF):** Primary Care Prescribing budget is forecasted to breakeven together with Locally Enhanced Services and Delegated Co-Commissioning. Potential cost pressures emerging from Digital First primary care activity has been assessed and accounted for in the risks and mitigations. The CCG is working closely with the Primary Care team to manage the position. .
- Following the 2018/19 Learning Disabilities joint funding pilot and subsequent negotiations, the 2019/20 programme will include an in-year review process that will determine the health contributions to LBH and will form the basis of ongoing work in this area. The cost associated with this has now been included in the financial plans for the year.

- At month 5 City & Hackney CCG declared a breakeven position. The reported position has been fully risk assessed with all known acute, non-acute and primary care risks and mitigations forming part of the forecast outturn for 2019/20.
- The recurrent QIPP target of £5m is fully identified and expected to deliver on plan. Any slippage will be mitigated through new savings and/or over achievement from existing schemes. Work is underway to identify and develop new savings schemes for the coming year 2020/21.
- The acute portfolio was reviewed using Month 4 freeze data to arrive at a break even position. Barts, Moorfields and London Ambulance Service are over plan at month 5 but the overall position has been mitigated through acute reserves and favourable variances at Chelsea and Westminster Hospital, Guys and Imperial.
- Non-Acute expenditure which includes Learning Disabilities, Continuing Health Care and Programme Projects were reported on plan. Whilst the block arrangement with the main mental health provider ELFT is on plan, the Community Health Services (CHS) block is being rebased to ensure finance and activity data are in line with the contract. The outcome of the rebasing exercise is to be agreed with the Homerton with an increase to the final contract value of £0.8m to be made in the coming weeks.
- **Pooled budgets:** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF), Integrated Independence Team (IIT) and Learning Disabilities. At Month 5 these are expected to break even.
- **Unplanned Care:** At Month 5 the £0.8m adverse forecast was being driven mainly by over performance on the Bart's contract -£0.7m. Areas of over performance in the main were Non-elective mostly in respect of A&E clinic, palliative medicine, general medicine, respiratory
- **Planned Care**: The £1.1m adverse position at Month 5 was driven by the Barts contract - £0.8m. In addition, Moorfields reported a forecast position of £0.3m. This in the main, was due to high cost drugs and devices, QIPP under delivery and Outpatients. The CSU is due to respond to the CCGs queries on high cost drug charges at this month's acute review meeting.
- **Corporate & Reserves**: Reporting a £1.8m favourable position which includes the acute general reserves being used to mitigate the CCG's position.

***Accruals are included in the CCG YTD and forecast position, however they are only included in the forecast position of LBH and CoLC.**

City and Hackney CCG - Risks and Mitigations Month 05, 2019/20

Summary and Progress Report on Financial Risks and Opportunities to Month 5 - 31 August 2019

Ref:		Description	Risks/ (Opps) £'000	Prob. %	Recurrent £'000	Non Recurrent £'000	Narrative
1	Risk	Homerton Acute performance	2,000	23%	416	51	Risk of over-performance, PTL impact and external audit costs.
2		System Resilience	678	100%	0	678	Subject to FPC review.
3		Bart's Acute Performance	2,100	85%	1,777	0	Risk based on month three over-performance and assessment.
4		Outer Sector - Acute Performance	900	22%	68	126	Over-performance across out of area portfolio.
5		Non Contract Activity	400	0%	0	0	Risk of cost pressure emerging during the year.
6		Continuing Healthcare, LD & EOL	400	0%	0	0	Risk attributable to high cost packages.
7		Joint LD programme	800	0%	0	0	Gross risk above the estimated £1.9m budget.
8		Integrated Learning Disability Service	450	0%	0	0	Risk of cost pressure emerging following the transfer of service from the Homerton to ELFT.
9		Better Care Fund	728	100%	728	0	Increase contribution from 1.79% to 6.8% pending resolution
10		Non Acute	1,306	94%	1,227	0	Contract rebasing and renegotiation.
11		Programme Costs	300	0%	0	0	Integrated commissioning programme development.
12		Estates	500	60%	0	300	Primary Care estates infrastructure.
13		Ringfenced Budgets	1,441	0%	0	0	Assigned to commitments.
14		Prevention Standard	2,000	100%	0	2,000	Establishing a baseline for system prevention & innovation.
15		NELCSU to NELCA POD Transfer	200	100%	0	200	Cost pressure associated with transfer.
16		QIPP Under Delivery	642	0%	0	0	Under delivery of agreed schemes.
17		Primary Care - Rent Revaluation	500	0%	0	0	Retrospective rent increases.
18		Primary Care - Rates	300	0%	0	0	Increased rateable value on estate.
19		Primary Care - Digital First	1,022	82%	0	839	Contribution to Hammersmith & Fulham CCG.
Total Risks			**16,667**	**50%**	**4,216**	**4,194**	
1	Opps	Acute Claims and Challenges	(1,400)	42%	(582)	0	Based on historic trend.
2		Acute Reserves	(2,778)	60%	(1,679)	0	To contain acute cost pressures.
3		Strategic Reserve	(206)	0%	0	0	Reserve utilised for LD commitment.
4		Contingency	(2,377)	0%	0	0	Contingency held.
5		Assigned Budgets	(2,849)	62%	(1,755)	0	Commissioning arrangements to be formalised.
6		Ringfenced Allocations	(1,441)	0%	0	0	Assigned to commitments.
7		Running Costs	(1,177)	17%	(200)	0	Running cost underspend.
8		Prior Year and Dispute Resolution	(7,963)	53%	0	(4,194)	Opportunities arising from settlement of disputed items and accruals.
Total Opportunities			**(20,191)**	**42%**	**(4,216)**	**(4,194)**	
					0	**0**	
				In-Year Surplus		**0**	
				Brought Forward Underspend		**(30,418)**	
				Carried Forward Underspend		**(30,418)**	

*Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

City of London Corporation – Position Summary at Month 05, 2019/20

				YTD Performance			Forecast Outturn		
	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Outturn £000's	Variance £000's	Prior Mth Variance £000's
Pooled Budgets	Comm'ned & *DD	Unplanned Care	65	7	-	7	65	-	-
		Planned Care	85	30	-	30	85	-	-
		Prevention	60	15	30	(15)	60	-	-
Pooled Budgets Grand total			210	52	30	22	210	-	-

	ORG Split	WORKSTREAM	Annual Budget £000's	Budget £000's	Spend £000's	Variance £000's	Outturn £000's	Variance £000's	Prior Mth Variance £000's
Aligned Budgets	Comm'ned & *DD	Unplanned Care	294	30	30	0	294	-	-
		Planned Care	4,548	1,877	1,768	108	4,229	319	233
		Prevention	1,447	431	339	92	1,447	-	-
		Childrens and Young People	1,532	451	535	(83)	1,532	-	-
		Non - exercisable social care services (income)	(180)	(60)	(76)	16	(175)	(5)	(12)
Aligned Budgets Grand total			7,641	2,729	2,595	133	7,327	314	221
Grand total			**7,851**	**2,781**	**2,625**	**156**	**7,537**	**314**	**221**

* DD denotes services which are Directly delivered .
* Aligned Unplanned Care budgets include iBCF funding - £265k
* Comm'ned = Commissioned

- At Month 05 the City of London forecasts a year end favourable position of £0.3m, an improvement on the Month 04 position.
- **Pooled budgets** The Pooled budgets reflect the pre-existing integrated services of the Better Care Fund (BCF) ,Integrated Independence Team (IIT) and Learning Disabilities. These budgets are forecast to break even at year end.
- **Aligned budgets** are forecast to under spend at year end. This is being driven by underspend in Residential Care (older people) - £0.1m and Home help services £0.07m.
- No additional savings targets were set against City budgets for 2019/20

***Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.**

London Borough of Hackney – Position Summary at Month 05, 2019

	ORG Split	WORKSTREAM	Total Annual Budget £000's	Pooled Annual Budget £000's	Aligned Annual Budget £000's	YTD Performance Budget £000's	YTD Performance Spend £000's	YTD Performance Variance £000's	Forecast Fcast Spend £000's	Forecast Variance £000's	Forecast Prior Mth Variance £000's
Pooled and Aligned Budgets	Commissioned & Directly Delivered	LBH Capital BCF (Disabled Facilities Grant)	1,525	1,525	-	636	463	172	1,525	-	-
		LBH Capital subtotal	1,525	1,525	-	636	463	172	1,525	-	-
		Unplanned Care (including income)	5,299	1,029	4,270	2,208	2,729	(521)	4,806	493	380
		Planned Care (including income)	63,946	29,665	34,281	26,644	35,449	(8,804)	67,693	(3,747)	(3,629)
		CYPM	9,049	-	9,049	3,770	8,380	(4,610)	9,049	-	-
		Prevention	23,554	-	23,554	9,814	5,304	4,511	23,544	10	8
		LBH Revenue subtotal	101,848	30,694	71,154	42,437	51,861	(9,425)	105,092	(3,244)	(3,241)
Grand total			**103,373**	**32,219**	**71,154**	**43,072**	**52,324**	**(9,252)**	106,617	(3,244)	(3,241)

103,373

- The Mental Health service provided in partnership with the East London Foundation Trust (ELFT) within this work stream is forecast to overspend by £552k. The overall position is made up of two main elements - a £724k overspend on externally commissioned care services and (£174k) underspend across staffing-related expenditure.
- Ongoing challenges around the Housing Related Support (HRS) savings programme target of £4.5m is resulting in a £0.8m overspend.

- **Unplanned Care**: The majority of the Unplanned care forecast underspend of £493k relates to Interim Care and is offset by overspends on care packages expenditure which sits in the Planned Care work stream.
- **In summary**, the Planned Care overspend is partially offset by forecast underspends in Unplanned Care reducing the overall revenue overspend to £3.2m.
- **CYPM & Prevention Budgets:** Public Health constitutes vast majority of LBH CYPM & Prevention budgets which is forecasting a very small overspend.

- At Month 5 LBH reports a forecast overspend of £3.2m
- **Pooled budgets** reflect the pre-existing integrated services of the Better Care Fund (including the Integrated Independence Team IIT) and Learning Disabilities.
- **Planned Care:** The Planned Care workstream is driving the LBH over spend.
  - Learning Disabilities Commissioned care packages within this work stream is the most significant area of pressure with a £1.08m overspend. This is significantly less than last year due to the application of both budget growth and one-off funds in this area.
  - Work is ongoing with CCG colleagues to embed the joint funding model for high cost Learning Disability packages as business as usual. The CCG have committed to ringfence £1.9-£2.7m within their financial planning for 2019/20 and a contribution of £1.9m has been factored into the forecast.
  - Progress has been slow in embedding the joint funding model which has resulted in fewer than expected cases going through the panel process to date. This is being closely monitored by all partners and measures have been taken to ensure completion of all joint funding assessments by the end of the year, which includes having dedicated project support from the PMO in adult services to ensure the smooth day to day operation of the process, given its high priority and funding risk.
  - Physical & Sensory Support is forecasting an overspend of £512k, whilst Memory/Cognition & Mental Health ASC (OP) is forecasting an overspend of £505k. The cost pressures being faced in both service areas has been driven by the significant growth in client numbers as a result of hospital discharges. A set of management actions have been agreed to mitigate the ongoing cost pressures within the service as follows:
    - Multidisciplinary Team Review (MDT) of Care Packages which has already delivered savings of £667k to date.
    - Promoting Personalisation and increasing uptake of direct payments.
    - Three conversations

  To note the potential impact of the above management actions on the overall finance position would be offset by any additional demand coming through the service.

***Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.**

London Borough of Hackney - Risks and Mitigations Month 05, 2019

London Borough of Hackney

Risks	Full Risk Value £'000	Probability of risk being realised %	Potential Risk Value £'000	Proportion of Total %
Pressures remains within Planned Care	3,241	100%	3,241	100%
Learning Disability Joint Funding	1,900		1,900	
TOTAL RISKS	**5,141**	**100%**	**5,141**	**100%**

Mitigations	Full Mitigation Value £'000	Probability of success of mitigating action %	Expected Mitigation Value £'000	Proportion of Total %
Work is ongoing with CCG colleagues to embed the joint funding model for high cost Learning Disability packages as business as usual. There is an agreement between both parties for all packages to be reviewed for joint funding.	TBC	TBC	TBC	TBC
Multidisciplinary Team Review of Care Packages (£667k savings achieved to date)	TBC	TBC	TBC	TBC
Personalisation and DPs - Increasing Uptake	TBC	TBC	TBC	TBC
Three Conversations	TBC	TBC	TBC	TBC
Review one off funding	3,241	100%	3,241	100%
Uncommitted Funds Sub-Total	**3,241**	**100%**	**3,241**	**100%**
Actions to Implement				
Actions to Implement Sub-Total	**0**	**0**	**0**	**0**
TOTAL MITIGATION	**0**	**0**	**0**	**0**

*Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

London Borough of Hackney – Wider Risks & Challenges

- Over the period 2010/11 to 2019/20 core Government funding has shrunk from £310m to around £170m, a 45% reduction – this leaves the Council with very hard choices in identifying further savings.
- Fair funding review could redistribute already shrinking resources away from most inner London boroughs including Hackney.
- Demand for services increasing particularly in Children's Services, Adults and on homelessness services.
- Additional funding through IBCF and winter funding are one off and insufficient
- We await sustainable funding solution for Adult Social Care expected in the delayed Green Paper

*Accruals are included in the CCG YTD and forecast position , however they are only included in the forecast position of LBH and CoLC.

Integrated Commissioning Fund – Savings Performance Month 04, 2019/20

City and Hackney CCG

- At the end of month 5 the CCG is reporting £1.88m savings delivered against a year-to-date (YTD) plan of £2.01m.
- QIPP schemes have been risked assessed for financial delivery, with the most risky projects RAG rated HIGH. Schemes have been risked assessed based on YTD actual delivery position and/or implementation status.
- Included in the £5m FOT are high risk schemes totalling £642k. Remedial actions have been requested and being implemented to reduce risk of non-delivery of 2019/20 QIPP savings target.
- It is also important to note that schemes totalling £327k have been closed, savings are not expected for these schemes in 2019/20 thus not included in the £5m FOT.

Under-delivery and Mitigations:

- Included in the £5m FOT are high risk schemes totalling £642k however there are some mitigations being reported in the current position:
  - Outpatient Transformation Programme - Virtual Fracture Clinic delivering savings from quarter 2.
  - Higher than planned savings being delivered by the Termination of Pregnancy scheme.
  - Higher than planned savings targets deducted from the Barts and UCLH contracts relating to prescribing QIPP – Biosimilars.
  - UCLH patient transport scheme agreed in the block contract mitigating the UCLH reducing FA's and FUP's which was not agreed into the block contract.
  - Non recurrent savings released from Estates dispute resolutions.

London Borough of Hackney

- LBH has agreed savings of £0.9m for 2019/20 of this we have delivered £0.1m in 2019/20. The shortfall in savings relates to delays in achieving the overall Housing Related Support (HRS) savings programme target of £4.5m, resulting in a £0.8m pressure. The service continues working in collaboration with existing providers to develop a sustainable service model, and are confident these savings will be delivered next year as part of the ongoing redesign of HRS.

City of London Corporation

- The CoLC did not identify a saving target to date for the 2019/20 financial year.

Title of report:	A New S75 Provider Agreement for the Integrated Learning Disability Service
Date of meeting:	10th October 2019
Lead Officer:	Simon Galczynski, Director of Adult Social Care (LBH)
Author:	Tessa Cole, Head of Strategic Programmes and Governance Carlene Liverpool, Project Manager
Committee(s):	***Planned Care Core Leadership Group for information*** - 17th September 2019 ***Integrated Commissioning Board – for agreement*** - *10th October 2019*
Public / Non-public	Public.

Executive Summary:

Hackney's Integrated Learning Disability Service (ILDS) is a jointly commissioned service made up of health and social care professionals. The service underwent a strategic review in 2018 and a new operating model is currently being implemented.

This report provides details of the new section 75 Provider Agreement. From 2nd July 2018 new partnership arrangements came into effect following the decision of Homerton University Hospital Trust to withdraw from the service.

Under these new arrangements London Borough of Hackney (LBH) hosts the service and assumes the lead role for social care services; East London Foundation Trust (ELFT) takes on the lead role for health services. The service is based at Hackney Service Centre, with specialist health clinics operating from St. Leonard's Hospital, Nuttall St, London N1 5LZ.

Recommendations:

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

- To **APPROVE** the attached Section 75 Provider Agreement which sets out the operational arrangements and boundaries of responsibility between the two providers in the partnership.

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

- To **APPROVE** the attached Section 75 Provider Agreement which sets out the operational arrangements and boundaries of responsibility between the two providers in the partnership

Strategic Objectives this paper supports:

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

Specific implications for City

- Health services only are provided by the ILDS to City of London residents.

Specific implications for Hackney

- The London Borough of Hackney will continue to host the service and lead with providing social care services.
- The East London Foundation Trust will take over the lease for the clinic space at St. Leonard's hospital.

Patient and Public Involvement and Impact:

The design of the new operating model was informed by a series of consultation and engagement events with a wide range of stakeholders including health and social care staff, service users and carers.

Clinical/practitioner input and engagement:

In addition to consultation and engagement events, staff representatives from each professional discipline were regular attendees at a series of workshops in 2018/19. The purpose of these was to co-produce new operational workflows for each of the care pathways. These workshops were also used to raise potential issues, concerns or potential blockages in the system and the group collaborated to recommend sustainable,

workable solutions. Clinicians and practitioners were also consulted on and helped shape the role responsibilities listed in the Section 75 attached to this report in 2019/20.

Equalities implications and impact on priority groups:

The service supports people with Learning Disabilities and people with Mental Health conditions. The findings from the consultation and engagement exercises with staff, service users and carers were used to inform the development of the new operating model. The overall purpose of the service redesign was to improve the service user experience and outcomes for a group who have protected characteristics under the Equalities Act (2010).

Safeguarding implications:

A key function of this service is to support vulnerable adults to be safe and adult safeguarding is at the core of service delivery

Impact on / Overlap with Existing Services:

The new operating model launched informally from February 2019. Given the complexity of typical service user needs and their potential vulnerabilities, the strategic partners agreed that a phased approach to rolling out the new model was vital in order to preserve continuity of care and robustly manage the risks involved.

Phase One involved setting up the Preparing for Adulthood and Intensive Support Teams, because the service user cohorts and boundaries of responsibility with the other teams across the service were easily defined. This will be followed by Phase Two and any lessons learned from Phase One will inform the process. In the meantime, the Referral & Review and Ongoing Support teams will to operate as one entity.

Main Report

Background and Current Position

Hackney's Integrated Learning Disability Service (ILDS) is an integrated multi-agency, multi-disciplinary team, providing specialist health and social care support to adults with Learning Disabilities, who are residents of the London Borough of Hackney and the City of London, and have a GP in the area. The service is jointly-commissioned by the Council and the CCG and plays an important role in delivering the objectives of NHS England's Transforming Care Programme. The service is based at Hackney Service Centre, with specialist health clinics operating from St. Leonard's Hospital, Nuttall St, London N1 5LZ.

ILDS is a highly specialist service and Hackney Council not only hosts it but also provides specialist learning disability social workers. ELFT provides a range of specialist clinicians including Psychiatrists, Psychologists, Physiotherapists, Occupational Therapists, Speech and Language Therapists and specialist Community Nurses.

The purpose of ILDS is:

1. To assess and meet the needs of people with a diagnosed learning disability, including young people transitioning into adulthood.
2. To support easy access to mainstream services and appropriate responses from the professionals involved.
3. To enable all services to provide integrated, effective person-centred support to people with learning disabilities.
4. To provide direct specialist clinical, therapeutic and social care support for people with complex learning disabilities and/or mental health needs.
5. To respond positively and effectively to vulnerable people who are in need of support or who are in crisis.

The service is currently rolling out a new operating model which is designed to improve the quality of health and social care provision within the service through the introduction of more integrated care pathways. These improvements are augmented by changes to the strategic partnership arrangements and this report provides details of the new section 75 Agreement between the two main providers in the partnership. Under these new arrangements London Borough of Hackney (LBH) hosts the service and assumes the lead role for social care services; East London Foundation Trust (ELFT) takes on the lead role for health services.

Options

The Integrated Commissioning Board were presented with an options appraisal for four potential operating models in 2018 and approved the recommended model.

Proposals

Please see attached Section 75 Provider agreement for endorsement.

Conclusion

The ICB are requested to endorse the attached Section 75 Provider agreement, which will form the basis for the future partnership arrangements for Hackney's Integrated Learning Disability Service.

Supporting Papers and Evidence:

Appendix 1: Section 75 agreement between LBH and ELFT.

Sign-off:

Workstream SRO: Siobhan Harper Workstream Director Planned Care London Borough of Hackney: Ann Canning Group Director of Children, Adults & Community Health

City of London Corporation: Andrew Carter Director of Community and Children's Services.

City & Hackney CCG: Siobhan Harper Workstream Director Planned Care

(1) EAST LONDON NHS FOUNDATION TRUST

and

(2) LONDON BOROUGH OF HACKNEY

AGREEMENT v Final Draft

SECTION 75 NATIONAL HEALTH SERVICE ACT 2006

PARTNERSHIP AGREEMENT

IN RESPECT OF

INTEGRATED PROVISION

FOR

LEARNING DISABILITY HEALTH AND SOCIAL CARE SERVICES

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Schedules

Appendices

THIS AGREEMENT is made on **xx**

BETWEEN

(1) **EAST LONDON NHS FOUNDATION TRUST** (the Trust") situated at Trust Headquarters, Robert Dolan House, 9 Alie Street London, E1 8DE, of the one part; and

(2) **THE LONDON BOROUGH OF HACKNEY** ("the Council") situated at Hackney Town Hall, Mare Street, London E8 1EA, of the other part.

WHEREAS:

A. This Agreement is intended by the Partners to establish on xxx 2019 a joint management arrangement for provision of integrated Learning Disability Services pursuant to Section 75 of the Act (as defined below).

B. The purpose of this Agreement is to facilitate the provision and development of the Services in the manner and locations specified in this Agreement and which Services are to be provided from separate funds approved by each Partner, using the Trust's and the Council's powers, and is limited to eligible people within the Council's administrative area.

C. The Partners have agreed that the Council will manage the Services on behalf of the Partners. The Trust seconded staff providing clinical Services will be line managed by the Council but will receive professional supervision by the Trust for the duration of this Agreement.

D. This agreement incorporates wide consultation with relevant managers and staff. As the agreement does not incorporate any substantive changes to front line service delivery Partners considered that it was not necessary at this stage to undertake any specific consultation in relation to this Agreement with service users.

E. The intention of the Partners through this Agreement is to improve outcomes for adults with a learning disability in the borough of Hackney and City of London CCG boundary area, in accordance with the Section 75 Commissioning Agreement for Hackney's Integrated Learning Disability Service 27th November 2017.

F. The Parties shall enter into a Management Agreement on the date hereof for the provision of Managed Staff.

G. The Parties have thus far been operating under a Memorandum of Understanding (MOU) since 2nd July 2018.

IT IS AGREED AS FOLLOWS:

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, except where the context otherwise requires, the following expressions shall have the meanings respectively ascribed to them:

Act	**means the National Health Service Act 2006;**
Agreement	means this Agreement and any variation of it from time to time agreed in writing between the Partners;
Best Value	the Authority's duty under section 3 of the Local Government Act 1999 to make arrangements to secure continuous improvement in the way in which its Functions are exercised, having regard to a combination of economy, efficiency and effectiveness.
Budgets	Annual expenditure and income estimates established by each Partner in accordance with Clauses 5 and 9.
Care Programme Approach	The Care Programme Approach (CPA) is the national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focused on recovery.
Clinical Governance	the clinical governance system implemented by a party to create and foster an environment for excellence in clinical care which in turn will enable the relevant party to meet its duty to continuously seek and implement improvements to the quality of health services and safeguarding of high standards of care.
Commencement Date	means xxx 2019
Contract Commissioning Requirements	procurement requirements for contracting as required by Law and/or the Department of Health, NHS England or any other public regulator or authority, and any relevant guidelines or requirements, contract standing orders, financial requirements, scheme of delegation and other relevant requirements as may be set out in the Council's constitution or policies or in the Trust's constitution or policies and/or procurement best practice guidance and / or any other requirements or policies notified to each of the Partners from time to time
Council	means the London Borough of Hackney;
Council Health-Related Functions	the functions of the Council for the purposes of this Agreement set out in Schedule 2 which fall within the health-related functions of the authorities prescribed under Regulation 6 of the Regulations.
Data Protection Legislation	this includes: (a) the Data Protection Act 2018 (DPA 2018); (b) Regulation 2016/679 (GDPR); (c) the Regulation of Investigatory Powers Act 2000; (d) the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699); (e) Directive 2002/58/EC concerning the processing of Personal Data and the protection of privacy in the electronic communications sector; (f) the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2003/2426); and (g) all applicable laws and regulations relating to processing personal data and privacy, including the guidance and codes of practice issued by the Information Commissioner, where applicable

Financial Year	means the financial year from 1st April in any year to 31st March in the following calendar year;
Functions	together the Trust's Health Related Functions and the Council's Social Care-Related Functions.
Key Performance Indicators	means those indicators set out in Schedule 8.
Managed Staff	means those personnel who are employees, consultants and agency staff of the Council and who it has been agreed will be managed and directed in their duties by the Trust according to policies and procedures agreed by the Partners in accordance with the Management Agreement;
Management Agreement	means the terms for supervision and management of the Managed Staff in the form of Management Agreement and a copy of which is appended at Appendix 1 dated xxx 2019
Partners	means the Trust and the Council, and the term "Partner" shall mean either one of them; the term "Partnership" shall be construed accordingly;
LDPMG	means the Learning Disability Partnership Management Group responsible for overseeing and monitoring the Partnership Agreement and the performance of Integrated Service delivery and terms of reference are set out in this Agreement and in accordance with Schedule 10;
Quarter	means each of the following periods in any financial year: 1 April to 30 June 1 July to 30 September 1 October to 31 December 1 January to 31 March and "Quarterly" shall be construed accordingly.
Regulations	means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, S.I. No. 617 (as amended);
Service Improvement Plan	means the Trust and the Council's annual service delivery and improvement plan for learning disability services. This shall include any objectives for change and delivery commitments delivered under this Agreement. This plan is to be implemented by the Trust on behalf of the Partners in the Financial Year. This plan will be adopted following approval by the PMG and any specific additional sign off requirements of each partner. The Service Improvement Plan will incorporate the Budgets and note any substantive revisions to the Schedules 1, 3, 4, 5 and performance framework here appended at Schedule 8 as required. The service improvement plan will be informed by and support delivery of the longer-term plans including the City and Hackney CCG Strategic Plan and Investment Plan as relates to Mental Health Services and any associated commissioning and project delivery plans including those led by the London Borough of Hackney
Service User	means any person eligible and receiving the benefit of Services within the scope of this agreement;
Services	means the Services set out as within the scope of this agreement detailed in Schedule 3a;
Social Value	means the responsibilities placed on the Authority by the Public Services (Social Value) Act 2012 which requires that the Authority must consider how what is proposed to be procured might improve the economic, social and environmental well-being of the relevant

	area, and how in constructing the procurement it might act with a view to seeking that improvement.
Staff	means the persons employed, contracted, engaged or managed by the Partners to carry out the Service from time to time.
Term	means the period from the Commencement Date and shall continue for a period of 5 years unless this Agreement terminates in accordance with Clause 16
Trust	means East London Foundation NHS Trust (and any successor to its statutory function).
Trust Health Related Functions	The functions of the Trust for the purposes of this Agreement set out in Schedule 2 which fall within the Trusts functions prescribed under Regulation 5 of the Regulations.

1.2 Save to the extent that the context or the express provisions of this Agreement otherwise require:

1.2.1 references to any gender include any other gender and words in the singular include the plural and words in the plural include the singular;

1.2.2 references to any Statute or statutory provision shall be deemed to refer to any modification, amendment or re-enactment thereof for the time being in force whether by Statute, Regulation, Guidance, Direction or Directive which is intended to have direct application within the United Kingdom and has been adopted by the Council of European Communities;

1.2.3 headings and the Index are inserted for convenience only and shall be ignored in interpreting or in the construction of this Agreement;

1.2.4 references in this Agreement to any Clause or Sub-Clause or Schedule or Appendix without further designation shall be construed as a reference to the Clause or Sub-Clause of or Schedule or Appendix to this Agreement so numbered;

1.2.5 any obligation on either of the Partners shall be a direct obligation or an obligation to procure as the context requires;

1.2.6 any reference to “indemnity” or “indemnify” or other similar expressions shall mean that the relevant Partner indemnifies, shall indemnify and keep indemnified and hold harmless the other Partner; and

1.2.7 any reference to a person shall be deemed to include any permitted transferee or assignee of such person and any successor to that person or any person which has taken over the functions or responsibilities of that person but without derogation from any liability of any original Partner to this Agreement.

2. TERM

2.1. This Agreement shall commence on the Commencement Date and shall continue for a period of 5 years unless terminated in accordance with clause 16.

3. PARTNERSHIP ARRANGEMENTS

3.1 The Parties enter into this Agreement under section 75 of the NHS Act 2006 to commission integrated learning disability services to better meet the needs of the Service Users of Hackney than if the Parties were operating independently.

3.2 The Partners shall be obliged to act in accordance with the Aims and Objectives of this Agreement as set out in Schedule 1a.

3.3 The Partners Aims and Objectives are intended to reflect the views of Staff, Service Users, carers and key partner's organisations (such key organisations agreed by the Partners) in a way that is both relevant and unifying.

3.4 The governance structure and performance management framework set out in schedules 10 and 8 respectively are intended to ensure delivery against the Partners overarching Aims and Objectives and improve the outcomes for Services Users.

3.5 Pursuant to 3.4, the governance structure shall facilitate and communicate progress and challenges of this Agreement to relevant stakeholders (as agreed between the Partners) in a way which is clear and transparent.

3.6 This agreement exists within the context of the Integrated Commissioning programme between City and Hackney CCG, London Borough of Hackney and City of London Corporation.

3.7 In particular, the Council will have the leading role in ensuring that managers and staff providing local services understand and promote the Partners Aims and Objectives.

3.8 The Parties shall enter into the Management Agreement on the date hereof.

4 GENERAL PRINCIPLES

4.1 Nothing in this Agreement shall affect:

4.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

4.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

4.2 The Partners agree to:

4.2.1 treat each other with respect and an equality of esteem;

4.2.2 be open with information about the performance and financial status of each; and

4.2.3 provide early information and notice about relevant problems.

4.3.4 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4.3.5 This Agreement sets out the mechanism through which the Partners will work together to commission services.

4.3 Service Outcome Principles

4.3.1 People should be supported to have a good and meaningful everyday life - through access to activities and services such as early year's services, education, employment, social and sports/leisure, suitable accommodation; and support to develop and maintain good relationships.

4.3.2. Care and support should be person-centred, planned, proactive and coordinated – with early intervention and preventative strategies based on bespoke solutions and keyworkers to coordinate and join up support.

4.3.3. People should have choice and control over how their health and social care needs are met – with information available in formats that is easily understood and with independent advocacy and personal budgets routinely offered as appropriate.

4.3.4. People should be supported to live in the community with support from and for their families/carers as well as paid support and care staff.

4.3.5. People should have choice about where and with whom they live – with a choice of housing including small-scale supported living, and the offer of settled accommodation.

4.3.6. People should be enabled to access mainstream NHS services so they can have they support they need e.g. Annual Health Checks, Health Action Plans, Hospital Passports etc. as appropriate.

4.3.7. People should be able to access specialist health and social care support in the community – via integrated specialist multi-disciplinary health and social care teams, available on an intensive 24/7 basis when necessary.

4.3.8. Where appropriate, people should be able to get support to stay out of trouble, with reasonable adjustments aimed at reducing or preventing anti-social or 'offending' behaviour.

4.3.9. When their health needs cannot be met in the community, people should be able to access high-quality assessment and treatment in a hospital setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

4.3.10 These principles have been informed by co-production with service users, carers and staff and are in line with the outcomes defined in the City and Hackney LD strategy.

4.3.11 The service will work in partnership with the CCG and Commissioning to maintain a risk register to support the Care Treatment review process in line with Transforming Care.

5 CONTRIBUTIONS- BUDGETS AND RESOURCES

5.1 The Partners shall each operate a non-pooled Budget for the Services during the Term of this Agreement.

5.2 Each Partner's Budget for the Financial Year 2018/2019 shall be as stated in Schedule 5.

5.3 Each Partner's Budget for each subsequent Financial Year of the Term shall be stated in a revised Appendix 1 to Schedule 5 by the 21st March of the preceding financial year.

5.4 The Council shall deliver the Services.

5.5 The Trust shall make available to the Council in support of the Service:

5.5.1 The health staff to work for the provision of the Services in the form and manner set out at Schedule 3b.

5.6 The premises and services are set out at Schedules 6 and 3a respectively.

6. TRUST HEALTH RELATED FUNCTIONS AND COUNCIL SOCIAL CARE RELATED FUNCTIONS

6.1 The Trust's Health Related Functions and the Council's Social Care Related Functions are set out in Schedule 2.

6.2 The Partners have agreed to the delegation by the Trust to the Council's Integrated Learning Disability Service so that the Council may exercise the Trust's learning Health Related Functions on its behalf.

7. STANDARDS OF CONDUCT

7.1 The Partners are committed to co-operating with one another under this Agreement and agree to:

7.1.1 keep one another informed;

7.1.2 liaise effectively;

7.1.3 work together in good faith; and

7.1.4 act in such a way as to achieve the Aims and Objectives set out in Schedule 1; and

7.1.5 be committed to the principles set out in this Agreement in relation to governance and financial management.

7.2 For the avoidance of doubt, the Partners shall act in accordance with clause 7.1 in so far as it is reasonably practicable to do so, taking account of the best interests of Service Users, statutory obligations and availability of resources.

7.2.1 The Partners will:

7.2.2 Comply with all relevant Law, any other national and local and other guidance on conduct and probity and good corporate governance (including the Council's constitution and the Trust's constitution) and any Contract Procurement Requirements and each Partner shall be aware of the obligations affecting the other; and

7.2.3 Ensure that the personnel of each Partner responsible for the day to day management of the Services shall carry out their responsibilities in such a manner to ensure fulfilment of the Functions to ensure compliance with the Partner's obligations under this Agreement and in accordance with their respective constitutions, standing orders, standing financial instructions, schemes of delegation and prime financial policies as relevant.

7.2.4 In accordance with Clause 4(2) of the Regulations, Partners have duly considered and met requirements for consultation. It was not necessary to carry out joint consultation on the proposed Agreement with service users, and other individuals and groups as there were not any substantive changes to the service delivery to that which underpinned the preceding agreement. Partners agree that any consultation

that may be required under Law during the Term or upon termination of this Agreement for any reason will be undertaken.

7.2.5 On entering this Agreement, the Partners shall, where required, notify the Department of Health of that fact in the prescribed form.

7.2.6 This Agreement shall not include the provision of any services commissioned by the NHS Commissioning Board.

7.2.7 Nothing in this Agreement shall prejudice or affect the rights and powers, duties and obligations of the Partners in the exercise of their functions as public bodies or in any other capacity.

8 THE SERVICE AND ITS OPERATION

8.1 The Council shall be responsible for service delivery and the day to day line management of all staff, including the Trust's managed staff, but excluding Medical Staff. The Consultant Psychiatrists in the Service will be line managed by ELFT's Clinical Director – Learning Disabilities and accountable to the Head of Service.

8.2 Specialist services shall be provided to Service Users in accordance with the provisions of Schedules 3 (a, b, and c) and 4.

8.3 The eligibility of service users to receive the service shall be assessed in accordance with the provisions of Schedule 1b.

8.4 The Council shall ensure that in making any decision with respect to a Service User, due consideration is given to the Service User's gender, sexual orientation, religious persuasion, racial origin, age, cultural and linguistic background, with reference to the Equality Act 2010 and the Human Rights Act 1998 and the Data Protection Act 2018 where appropriate.

8.5 The Council in its capacity as host shall manage and direct the duties of all of the staff including the Trust's managed staff in accordance with Schedule 4.

8.6 The Council and the Trust shall comply with all law and relevant regulations relating to the provision of the service or any part thereof, and in particular without limitation, complies with any National Minimum Standards as set out in the Care Standards Act 2000.

8.7 The Council and the Trust will collaborate to ensure that adequate numbers of staff are allocated to the provision of the service including the managed staff, and that those Staff members are competent and able to carry out their allotted tasks, including but not limited to, having the appropriate and up-to-date qualifications where applicable to that role.

9. BUDGET MANAGEMENT

9.1 Each Partner will be responsible for its own annual Budgets, including all payments and receipts in respect of its Budgets, monitoring of its Budgets, overspends, underspends and reporting of its Budgets.

9.2 ELFT bill on actuals to a maximum of the agreed budget. Any planned overspend will be flagged to the Partnership Board and they will agree how the financial risk of any potential overspend will be managed.

9.3 Only by agreement of the partnership management group will funding either come from the pooled commissioning budget or be escalated to the commissioner for additional funding. Any overspend not agreed with the Partnership Board will be at risk to the providers ELFT and LBH.

9.4 Where overspend is required to maintain budgeted staffing levels but is not approved, ELFT and LBH will work together though the partnership board to agree temporary amendments to delivery.

9.5 Budgets will be reviewed in accordance with Clause 5.

9.6 Each Partner will submit quarterly financial and staffing reports to the Learning Disability Partnership Management Group (LDPMG) as soon as possible after the end of each Quarter, but in any event within 40 days of the end thereof, and an annual return following the end of each year in line with statutory and local deadlines and requirements. Required contents of reports are set out in Schedule 5 and 8.

9.7 The governance arrangements shall be as set out in Schedule 10.

9.8 Each Partner shall pay its own costs and expenses incurred from time to time in the negotiation and management of this Agreement, save as expressly otherwise provided in this Agreement (including, without limitation the functions described at Schedules 5 and 10).

10 CHARGING FOR SERVICES

10.1 The Services provided through this Agreement for which the Council normally charges will continue to attract a charge. There is no intention to increase or expand charging arrangements through this Agreement, although the Council reserves the right to do this at any time for the Council's services only. NHS services that are free at the point of access will continue to be so.

10.2 All charges will be collected by the Council.

10.3 Care plans will ensure that, where a charge is made, it is carefully explained to Service Users at the outset, to avoid any misunderstanding that social care services are being charged for.

10.4 Decisions about the charging policies to be adopted will rest with the Council. Changes of policy will be reported to the Learning Disability Partnership Management Group (LDPMG). The Council will ensure that written operational policies exist which provide staff with clear guidance on which services are charged for and which are non-chargeable.

10.5 Both parties shall be liable for and indemnify and keep indemnified the other party from and against all costs claims expenses demands and liability arising from or as a result of the Council charging for any Services.

11 INDEMNITY AND INSURANCE

11.1 The Council will maintain public liability insurance for not less than £10 million for any one incident (the number of incidents to be unlimited), employer's liability insurance for not less than £10 million, and professional indemnity insurance for not less than £2 million.

11.2 The Trust will maintain unlimited non-clinical liability cover in respect of public liability, employer's liability, product liability and professional indemnity.

11.3 The Trust will ensure adequate cover for clinical negligence through an appropriate scheme for NHS Trusts and governance arrangements as set out in schedules 3 (a, b and c) and 4. The Council will also ensure it understands any potential liability for clinical negligence relating to its role and activities that are relevant to this agreement and, where required, will ensure appropriate cover.

11.4 Each Partner shall provide to the other upon request such evidence as may reasonably be required to confirm that the insurance arrangements are satisfactory and are in force at all times.

11.5 The Trust shall indemnify and keep indemnified the Council against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses whatsoever, whether arising in tort (including negligence), default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of itself, its Staff, or sub-contractors, except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the Council or its Staff. .

11.6 The Council shall indemnify and keep indemnified the Trust against all actions, proceedings, costs, claims, demands, liabilities, losses and expenses whatsoever, whether arising in tort (including negligence), default or breach of this Agreement, to the extent that any loss or claim is due to the breach of contract, negligence, wilful default or fraud of itself, its Staff, or sub-contractors, except to the extent that the loss or claim is directly caused by or directly arises from the negligence, breach of this Agreement, or applicable Law by the Trust or its Staff.

11.7 Each Partner agrees to work together, discuss with their insurers (or equivalent providers) and facilitate the working together of all parties as relates to any action to enforce (or not to enforce) any appropriate subrogated rights against any other Partner arising out of any liability under the Arrangements, to the extent that the sum claimed is (or is not recoverable) under the other Partner's insurance (or equivalent) arrangements.

12. REVIEW

12.1 The Trust Service Directors (as detailed in Schedule 10) will be responsible for ensuring a quarterly and annual review process of partnership arrangements are undertaken through the Partnership Management Group and with the full involvement Council members of the group.

Quarterly Reviews

12.2 The Partners shall carry out a quarterly review of the Partnership Arrangements within 30 days of the end of each Quarter and shall within 5 working days of completion of the report submit the report for consideration by the LDPMG setting out:

(a) the performance of the Arrangements against the performance management framework and Key Performance Indicators for Services in the preceding quarter; and

(b) any forecast overspend or under spend of the Budgets.

Annual Reviews

12.3 The Partners shall no later than the 1st November in each Financial Year review the provision of the Services and Budgets in this Agreement and shall within 5 working days of completion of the report submit the report to the LDPMG to include the following:

a) set out the agreed aims and outcomes for the Service;

a) describe any changes or development required for the Service;

b) information on the achievements of Key Performance Indicators;

c) provide information on how changes in funding or resources may impact the Services; and

d) include details of any required changes to Budgets.

e) Set out the performance and achievements over the previous year for the Service.

12.4 The Partners shall use reasonable endeavours in each Financial Year to agree by 31st December, draft Budgets and Staffing for the following Financial Year for consideration by the LDPMG.

12.5 The Partners shall confirm Services, Budgets, Staff, Premises and any changes to services, financial and staffing procedures by no later than 21st March in each preceding Financial Year for the following Financial Year and this shall be incorporated into this Agreement as revisions to Schedules 1 to 6 of this Agreement.

12.6 Review in accordance with Clauses 12.1 to 12.3 shall be conducted in good faith and in accordance with the governance arrangements set out in Schedule 10.

12.7 The Parties shall endeavour to comply with the Service Improvement Plan approved by LDPMG in accordance with Schedule 10.

12.8 No provision of this Agreement shall prevent the Partners making additional contributions of non-recurring monies to their respective Budgets from time to time.

13. CONFLICTS OF INTEREST

13.1 The Partners shall be responsible for ensuring that its Staff does not put themselves in a position whereby duty and private interest conflict.

13.2 Without prejudice to the generality of Clause 13.1, the Partners each have and shall comply with their own policies for identifying and managing conflicts of interest which include:

a) any existing conflicts of interest or potential conflicts of interest;

b) any conflict of interest or potential conflict of interest which may arise in the future;

c) ensuring that additional employment (paid or voluntary) may not be undertaken by any staff working within this Agreement which conflicts with

or is detrimental to any of the Partners' interests, or which in any way weakens public confidence or affects the ability of the Partners to discharge their duties in or under this Agreement.

d) providing that each Party shall require that any employee employed as part of this Agreement considers that a conflict of interest exists in relation to their own role or position in connection with this Agreement they shall notify and request guidance initially from their line manager (who shall inform the other members of the LDPMG where necessary).

e) The Partners shall ensure that their respective policies for managing and identifying conflicts of interest are maintained and, where possible, brought in to line with the highest ethical policy applying.

14. AUDIT

14.1 Each Partner shall:

14.1.1 arrange for the audit of the accounts relating to its Budget in accordance with its statutory audit requirements.

14.1.2 provide to the other Party any relevant audit reports on reasonable notice.

14.1.3 co-operate in the provision of Information, and access to Premises and Staff, to ensure compliance with any statutory inspection requirements, or other monitoring or scrutiny the Functions. The Partners shall implement recommendations arising from these inspections, where appropriate.

15. PUBLICITY

15.1 The Partners shall use reasonable endeavours to consult one another before making any press announcements concerning the Services or the discharge of either Party's Functions under this Agreement.

16. TERMINATION

16.1 This Agreement may be terminated either by agreement; or by not less than 90 days written notice from either Partner to the other, if either of the Partners has failed to confirm in writing its respective Budgets, Staffing, and Premises for the following Financial Year by the 21st March in the preceding Financial Year.

16.2 If the Trust or the Council fails to meet any of their respective obligations under this Agreement, the other Partner may by written notice require the Partner in default to take such reasonable action within a reasonable time-scale as the first Partner may specify to rectify such failure. Should the Partner in default fail to rectify such failure within such reasonable time-scale, the other Partner may give written notice to terminate this Agreement by not less than 30 days written notice.

16.3 In circumstances other than the above, either Partner may by not less than 4 months' notice to the other terminate this Agreement.

16.4 Any purported termination of this Agreement under this Clause shall be without prejudice to any continuing obligations of the Partners under Clauses 9 and 12 and the continued operation of the LDPMG until such obligations have been discharged.

17. EFFECTS OF TERMINATION

17.1 Notwithstanding any notice of termination in accordance with Clause 16:

17.1.1 the Management Agreement shall terminate;

17.1.2 the Trust and the Council shall continue to be liable to provide the Service in accordance with this Agreement for all current Service Users at the date of service of the notice of termination and to fulfil all obligations which are properly incurred pursuant to this Agreement prior to date of service of the notice of termination until the expiry of the agreement;

17.2 On the expiry of the Term, or if this Agreement is terminated in whole or in part for any reason:

f) the Partners shall agree how services will be provided in the future

g) premises and assets shall be returned to the contributing Party in accordance with the terms of their leases, licences or agreed schedule of condition;

h) information shall be returned to the contributing Party;

i) assets purchased from the Budgets shall be returned to the Party from whose Budget the purchase was made;

j) the relevant Party shall transfer to the other Party all records in its possession relating to the Trust's Health Related Functions or Council's Health Related Functions as applicable.

17.3 The provisions of the following clauses shall survive termination or expiry of this Agreement:

k) Clause 14 (Audit);

l) Clause 11 (Indemnities);

m) Clause 17 (Effects of Termination);

n) Clause 21 (Freedom of Information, Data Protection and Information Sharing);

o) Clause 22 (Confidentiality);

p) Clause 34 (Governing Law and Jurisdiction).

18. FURTHER ASSURANCE

18.1 Each party shall use all reasonable endeavours execute and deliver such documents and perform such acts as may reasonably be required for the purpose of giving full effect to this agreement.

19 VARIATION & VERSION CONTROL MANAGEMENT

19.1 No variation to this Agreement shall be effective unless it is in writing and signed by both the Partners.

19.2 Version control and updating of the agreement and its schedules, including the noted requirements in 19.1 will be the responsibility of the Learning Disability Partnership Management Group. Updating of schedules will take place on an annual basis in

line with the requirements set out in Clause 12 and be reported for approval to the Learning Disability Partnership Management Group.

19.3 Updating will pay full and due regard to any substantive changes to the agreement that would require agreement by either or both partners at a higher level than the Learning Disability Partnership Management Group. Further updating will take into account the requirements for each partner to take appropriate legal advice on such matters.

20. ASSIGNMENT AND SUBCONTRACTING

20.1 This Agreement and any right and conditions contained in it may not be assigned, sub-contracted or transferred by either Partner without the prior written consent of the other Partner, except to any statutory successor to the relevant function.

21. FREEDOM OF INFORMATION, DATA PROTECTION AND INFORMATION SHARING

21.1 The Partners acknowledge that each is subject to the requirements of Freedom of Information Act 2000 and the Environmental Information Regulations 2004 and shall assist and co-operate with one another to enable each Party to comply with these information disclosure requirements, where necessary.

21.2 Each Party shall (and shall procure that any of the Staff involved in the provision of the Services shall) comply with any notification requirements under Data Protection Legislation. Both Partners shall duly observe all their obligations under Data Protection Legislation, including General Data Protection Regulations 2016/679, which arise in connection with this Agreement.

21.3 To this extent the Partners are permitted to do so by law the Partners shall share information about Service Users to improve the quality of care and enable integrated working in accordance with agreed protocols.

21.4 Each partner will lead on and co-operate with regard to providing information and resolving enquiries from the various governance structures that they are accountable to including LBH councillor and Trust board member enquires.

22. CONFIDENTIALITY

22.1 The Partners shall:

22.1.1 keep confidential any information obtained in connection with this Agreement and personal Service User data subject to the GDPR and Data Protection Act 2018; and

22.1.2 take appropriate technical and organisational measures against unauthorised or unlawful processing of such personal data and against accidental loss or destruction of or damage to such personal data.

22.2 The Trust and the Council shall keep confidential any information acquired through their conduct of this Agreement and will take all reasonable steps to ensure that their employees do not divulge such information to a third party, without the express consent of both Partners and the Service User, except in accordance with the requirements for external audit, as may be required by law or where such information is already in the public domain.

23. BEST VALUE, SOCIAL VALUE AND CLINICAL GOVERNANCE

23.1 The Partners agree that all Services directly commissioned (where relevant) pursuant to this Agreement shall be subject to the requirements of Best Value, Social Value and Clinical Governance.

23.2 Notwithstanding their obligations under this Agreement to commission Services, the relevant Party shall continually monitor the Services to ensure that they are delivered economically, efficiently and effectively and shall use all reasonable endeavours to identify and implement efficiency savings and Social Value in the performance of the Services in accordance with its duty to attain Best Value and Social Value.

24. HEALTHWATCH

24.1 The Partners shall promote and facilitate the involvement of Service Users, carers and members of the public in decision-making concerning the Services.

24.2 The Council shall ensure the effective discharge of its obligations in relation to the establishment and development of Local Health Watch.

24.3 The Partners will generally co-operate and assist each other to ensure compliance with the Regulations.

25. DISPUTE AND RESOLUTION

25.1 In the event of a dispute over the application or interpretation of this Agreement, the dispute may be referred by the Partners in writing as follows:

25.1.1 in the first instance to the Learning Disability Partnership Management Group to resolve within 30 days;

25.1.2 in the second instance to the Group Director of Children, Adults and Community Health of the Council and the Chief Executive of the Trust who shall endeavour to resolve the dispute within a further 30 days; and

25.1.3 should the dispute remain unresolved within the timescales described in 25.1.1 and

25.1.2 above, the Partners shall endeavour to agree to refer the matter to an appropriate, independent and mutually agreed third party for resolution.

26. FAIR DEALINGS

26.1 The Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

27. EXCLUSION OF PARTNERSHIP AND AGENCY

27.1 The Partners expressly agree that nothing in this Agreement in any way creates a legal partnership between them.

27.2 Neither Partner nor any of its employees or agents will in any circumstances hold itself out to be the servant or agent of the other Partner, except where expressly permitted by this Agreement.

28. THE CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

28.1 The Contracts (Rights of Third Parties) Act 1999 has no application whatsoever to this Agreement.

29. POLICIES AND PROCEDURES

29.1 The Partners shall have mutual policies and procedures to ensure that relevant controls assurance, probity and professional standards are met.

29.2 When a mutual policy is not in place, the policies of the employing organisation apply. In relation to Health & Safety policies, where there is not a mutual policy, the policy of the Trust shall apply and if there is no Trust Health & Safety Policy on a specific matter, the policy of the Council shall apply.

30. COMPLAINTS

30.1 In accordance with Schedule 10, the Partners shall maintain a complaints policy.

30.2 The Council will provide the first point of contact for a complaints and Members' enquiry procedure that adheres to statutory requirements and covers both health and social care services. The aim will be to provide as seamless an experience for complainants as possible

30.3 If a complainant should complain directly to the Trust about the Service or Staff, this will be referred to the Council in the first instance.

30.4 Where complaints relate to specifically about service provision, Hackney Council will lead on the handling of the complaint, co-coordinating with ELFT where appropriate.

30.5 If a complaint relates solely to ELFT professional practice/regulations, the Head of Service will take advice from ELFT colleagues.

30.6 Both Partners will co-operate with one another in the handling and resolution of any complaint received in relation to the Service and complaints will be investigated in accordance with the Council's complaints procedure

31. NOTICES

31.1 All notices under this Agreement shall only be validly given if given in writing, addressed as follows:

31.1.1 if to the Trust addressed to its Chief Executive; or

31.1.2 if to the Council, addressed to its Group Director of Children, Adults & Community Health

32. SEVERABILITY

32.1 If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision

shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

33. WAIVER

33.1 The failure of either Party to enforce any of the provisions of this Agreement at any time or for any period of time shall not be construed to be a waiver of any such provision and shall in no matter affect the right of that Partner thereafter to enforce such provision.

33.2 No waiver in any one or more instances of a breach of any provision of this Agreement shall be deemed to be a further or continuing waiver of such provision in other instances.

34 GOVERNING LAW

34.1 This Agreement shall be governed by and construed in all respects in accordance with the laws of England.

IN WITNESS whereof the Partners have executed this Agreement as a Deed the day and year first before written.

THE COMMON SEAL of THE TRUST

was affixed to this Deed in the presence of:-)

Authorised Signatory_____

On behalf of THE MAYOR AND BURGESSES OF THE LONDON BOROUGH OF HACKNEY, the common seal;

was affixed to this Deed in the presence of:-)

Authorised Signatory_____

Date_____

SCHEDULE 1a:

Aims and Objectives

1. **Introduction**

1.1 This Agreement will enable the Partners to deliver effective support and to continue to improve the quality and clinical governance of the services for adults who have learning disability-related health and care needs. The overall aim is to deliver an integrated service, which provides good value for money and offers good outcomes for service users.

2. Aims, Objectives and Intended Outcomes

2.1 The key Aims and Objectives of the Agreement are described below. Intended outcomes are addressed in Schedule 8 (Integrated Performance Management Framework.

2.2 The Aim

2.2.1 To provide the highest quality learning disabilities and community care services so that we make a vital and positive difference to people's lives and the wider community in Hackney.

2.3 The Values

2.3.1 The Partners have four core values;

I. **We care**: Everyone is entitled to the highest quality care and to be treated with dignity and respect

II. **We are user led**: Everyone should be treated as an individual and in a way that offers them the choice, control and independence that they deserve.

III. **We are inclusive**: Everyone should have equitable access to appropriate services when they need them, and we actively seek suggestions from all on how we can improve.

IV. **We are committed to promoting independence and maximising people's well-being**: Everyone's potential to recover or achieve a better quality of life drives what we do and how we work.

2.4 Core Strategic Objectives

2.4.1 The Partners have a set of core strategic objectives which will enable the Partners to deliver its vision, demonstrate its values in practice and focus on the delivery of outcomes.

2.4.2 The overarching objective is to provide a fully integrated, balanced system where people get care in the right place at the right time from people with the right skills,

working across the artificial boundaries of ‘Learning Disability services’ and ‘mainstream’ services. Underpinning this is the aim that people with a learning disability will have positive experiences of care.

2.4.3 Specific objectives include:

- To ensure good outcomes through prevention, early intervention and building resilience, particularly in relation to skills development and preparation for adulthood.
- To maintain and sustain health and well-being through supported access to a wide spectrum of local supported living, work and lifestyle options.
- To assist people with learning disabilities and those supporting them to better understand the causes of ill-health and support them to specialist and mainstream services as and when required.
- To reduce health inequalities through improved access to a wide range of health supports, including annual health checks, screening programmes, diagnostic assessments and health action planning
- To enable people to be as independent or inter-dependent as they can safely be so they can lead fulfilling lives and participate in their local community.
- To strive for continuous improvement - working to achieve clearly defined priorities and encourage research and innovation.

3. Review and Improvement Priorities

3.1 Arrangements for review and planning of progress against the Aims and Objectives are set out in Schedule 10.

3.2 The annual Service Improvement Plan provides detail on the improvement priorities for the service.

SCHEDULE 1b:

Service Eligibility Criteria

Purpose

Hackney's local policy is to support people aged 18+ with a learning disability to meet their individual needs through universal/mainstream services. The purpose of this set of eligibility criteria is to distinguish between those people with a learning disability who are capable of accessing universal/mainstream services with low-level support, and those who are unable to do so without specialist health support because of *the complexity surrounding their individual needs*.

Access

ILDS will support people aged 18+ who:

- Have a diagnosed learning disability
- Meet the eligibility requirements of the Care Act (2014)
- Are resident within the London Borough of Hackney boundary, or
- Are registered with a GP within the health boundary of City and Hackney Clinical Commissioning Group.

Access to the service will be by formal diagnosis, and <u>all three</u> of the following criteria must be met for a person to be considered to have a Learning Disability (British Psychological Society, 2000)**:**

1) Significant impairment of intellectual functioning;
2) Significant impairment of adaptive/social functioning;
3) Age of onset before adulthood.

The classification of learning disability will be based on assessed impairments of both intellectual and adaptive/social functioning, <u>which have been acquired before adulthood</u>. On the Wechsler Adult Intelligence Scale (Wechsler, 1999), the mean is 100 and the standard deviation is 15. More than two standard deviations below the mean corresponds to an intelligence quotient **(IQ) of below 70.**

The local definition of *Learning Disability* covers adults with autistic spectrum conditions who also have a significant impairment of intellectual functioning, <u>but not those with higher IQs such as people with Asperger's syndrome.</u>

Situations where individuals <u>will be eligible</u> for ILDS support

- The person has documentary evidence of a profound, severe or moderate learning disability diagnosis.
- The person is already on the Learning Disability register.
- The person previously attended a Special School for children with profound, severe to moderate learning disabilities.

- The person has or had an Education Health and Care plan for a medically diagnosed learning disability when they were at school.
- The person has a specific diagnosis or syndrome usually associated with profound, severe to moderate learning disabilities e.g. Down Syndrome, Fragile X Syndrome, Retts Syndrome, Autistic Spectrum Disorder (but not Asperger's) etc.
- The person has already had a Cognitive Assessment, which indicated the presence of a profound, severe or moderate learning disability.
- The person, by virtue of the complexities surrounding their learning disabilities, has complex needs, which cannot reasonably be provided by other universal/mainstream services, because a multi-disciplinary approach is necessary.
- The person has, in addition to their learning disability, significant physical, sensory, communication, behavioural, psychological or mental health needs.

If the person has reached adult hood without support from learning disability services the referrer will need to be explicit about why the person cannot have their needs met by universal/mainstream services.

If the reason for referral does not directly relate to the person's learning disability, then this need should be met by universal/mainstream services.

People with mental health needs who have an IQ of between 50 and 69 they will only be deemed eligible for ILDS if they meet all three of the access criteria above. Otherwise they should be signposted to access generic psychiatric services.

Situations where individuals <u>will not be eligible</u> for ILDS support

- People with specific learning difficulties e.g. dyslexia without an associated learning disability, language disorder etc.
- Other disorders not associated with a learning disability e.g. Attention Deficit Hyperactivity Disorder, Autistic Spectrum Disorder, Personality Disorder (unless combined with a significant impairment of intellectual functioning), Drug and/or alcohol dependency.
- People with physical needs not associated with or affected by their learning disability, whose needs can be met within universal health and/or social care services.
- People who acquire a brain injury or accidents when aged over 18 years, or who develop an adult onset medical condition that leads to difficulties with cognitive functioning e.g. degenerative neurological conditions, dementia, stroke etc.
- People with high functioning Asperger's syndrome whose cognitive abilities are in the average range or above.
- People who have not met the thresholds for Hackney's Children with Disabilities Service.
- People with a borderline IQ, but whose functional ability may meet the eligibility criteria.

- People with a mild learning disability whose primary need is an anti-social personality disorder, drug and/or alcohol dependency.

NOTE: Local Education Authorities use the term learning difficulties not learning disabilities and define it differently (moderate learning difficulties in educational terminology equates closely to mild learning disabilities in Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Social care support

People who require a social care service will have their needs assessed in accordance with the Care Act (2014) eligibility criteria. A strengths-based approach will be taken and a Financial Assessment will apply.

Definitions

- ***Autism***

Also referred to as Autistic Spectrum Disorder (ASD) or Autistic Spectrum Condition (ASC). Autism is a lifelong developmental disability that affects how a person communicates with, and relates to, other people. It also affects how a person makes sense of the world around them. The three main areas of difficulty, which all people with autism share, are known as the 'triad of impairments'. They are difficulties with:

1) social communication (e.g. problems using and understanding verbal and non-verbal language, such as gestures, facial expressions and tone of voice)
2) social interaction (e.g. problems in recognising and understanding other people's feelings and managing their own)
3) social imagination (e.g. problems in understanding and predicting other people's intentions and behaviour and imagining situations outside their own routine).

Many people with autism may experience some form of sensory sensitivity or under-sensitivity to sounds, touch, tastes, smells, light or colours for example. People with autism often prefer to have a fixed routine and can find change incredibly difficult to cope with.

Autism is a spectrum condition, which means that while all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live relatively independent lives, while others such as those who also have a learning disability (estimated around 50%) may need more support.

[Source: '*Fulfilling and Rewarding Lives'*, Department of health, (2010)]

- ***Behaviour that challenges***

Behaviour can be described as challenging when it is of such an intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion.

Some people with a learning disability and/or autism display behaviour that challenges. 'Behaviour that challenges' is not a diagnosis and does not in itself imply any understanding as to the causes of the behaviour. The behaviour may be a way for someone to let people know what they want or how they feel, or to try and control what is going on around them, or be a response to physical or mental distress.

A variety of factors are likely to contribute towards the development and escalation of behaviour that challenges, these include (but are not limited to): biological and genetic factors, physical ill-health, impaired communication difficulties, mental ill-health, the impact of poverty and social disadvantage, quality of support and exposure to adversities. Some care and support environments may increase the likelihood of behaviour that challenges, including those with limited opportunities for social interaction and meaningful occupation, lack of choice and sensory input or excessive noise, as well as environments where physical health needs and pain go unrecognised or are not managed.

Behaviour that challenges can often result from the interaction between personal and environmental factors, and can include self-injury or physical aggression, severe agitation and extreme withdrawal, as well as behaviours that can result in contact with the criminal justice system – in some cases leading to someone being arrested, charged and convicted of an offence.

Some people may have a long and persistent history of behaviour that challenges, perhaps starting in childhood. In others, it may be highly episodic - arising only under specific circumstances of stress or when the individual has a physical or mental health condition. In others still, it can be traced to a specific life event, such as a bereavement. This means that even if someone does not display behaviour that challenges today, they may do so in the future.

[Source: *'Challenging behaviour, a unified approach'*, Royal College of Psychiatrists, British Psychological Society and Royal College of Speech and Language Therapists, (2007)].

Distinction from Mental Health

"*A mental health problem is a term used to cover a range of emotional, psychological or psychiatric distress experienced by people, including depression, anxiety and schizophrenia. Mental health problems can affect anyone at any time and may be overcome with treatment, which is not true of learning disability*." [Source: Mencap]

City and Hackney's Mental Health professionals use chapter V of the International Classification of Diseases (ICD-10) produced by the World Health Organization for classifying mental health disorders. A range of diagnostic tools are used, including:

1. Public Health Questionnaire (PHQ-9) self-assessment questionnaire
2. Generalised anxiety Disorder (GAD-7) self-assessment questionnaire

SCHEDULE 2:

The Trust's Health-related functions and the Council's Social Care-related functions

Part 1 - NHS Health-Related Functions of the Trust

SI 617 (2000), SI 2828(2008), SI 3166 (2008), SI 278 (2009), SI 1000 (2010), SI 3094 (2012)

(a) the functions of arranging for the provision of services under sections 3, 3A and 3B of, and paragraphs 9 to 11 of Schedule 1, to the National Health Service Act 2006, as amended by the Health and Social Care Act 2012, including rehabilitation services and services intended to avoid admission to hospital but excluding surgery, radiotherapy, termination of pregnancies, endoscopy, the use of Class 4 laser treatments and other invasive treatments and emergency ambulance services; and

(b) the functions of providing the services referred to in paragraph (a), pursuant to arrangements made by a clinical commissioning group or NHS England

(c) the functions of arranging for the provision of services under section 117 of the Mental Health Act 1983; and

(d) the functions of providing services referred to in paragraph (c) pursuant to arrangements made by a clinical commissioning group or NHS England

(e) the functions under Schedule A1 of the Mental Capacity Act 2005.

(f) the functions of making direct payments under: (i) section 12A (1) of the NHS Act 2006 (direct payments for health care); and (ii) the NHS (Direct Payments) Regulations 2010.

(g) National Health Service and Community Care Act 1990

Part 2 – Social Care, Support and Health Related Care Functions of the Council

SI 617 (2000), SI 629 (2003), SI 3504 (2005), SI 1172 (2010), SI 3094 (2012)

(a) The Care Act (2014) core legal duties and powers relating to adult social care and the specific requirements for mental health under section 75 and Schedule 4 (subject to finalisation of the Act's guidance and legal requirements which come into force from 1st April 2015).

(b) The Functions specified in Schedule 1 to the Local Authority Social Services Act 1970 except for the Functions under:

(i) subject to sub-paragraph (k), sections 22, 23(3), 26(2) to (4), 43, 45 and 49 of the 1948 Act (National Assistance Act 1948);

(ii) sections 6 of the Local Authority Social Services Act 1970;

iii) section 3 of the Adoption and Children Act 2002;

(iv) sections 114 and 115 of the Mental Health Act 1983;

(v) subject to sub-paragraph (l), section 17 of the 1983 Act; and

(vi) Parts VII to IX and section 86 of the Children Act 1989;

(c) The functions under sections 7 or 8 of the Disabled Persons (Services, Consultation and Representation) Act 1986;

(d) Where partners enter into arrangements under regulation 7(1) or 8(1) in respect of the provision of a service under any enactment mentioned in section 17(2)(a) to (c) of the 1983 Act, the function of charging for that service under that section.

(e) The functions of local authorities under or by virtue of sections 2B or 6C (1) of, or Schedule 1 to, the 2006 Act (NHS Act 2006).

SCHEDULE 3a:

Service Description

Hackney's Integrated Learning Disabilities Service promotes a social model of disability, whereby people with learning disabilities are enabled to be as independent or inter-dependent as they can safely be, so that they can lead fulfilling lives and participate in their local community. Services are provided within a framework that improves health and wellbeing, uses preventative approaches to ensure smooth transitions e.g. from children's to adult services.

The service delivers a wide range of specialist support via the following disciplines:

- Assessment
- Social care and review services
- Speech and Language Therapy (SALT)
- Physiotherapy
- Occupational Therapy
- Nursing
- Psychology
- Behavioural Therapy
- Psychiatry

Professionals will be split across 4 multi-disciplinary teams to provide 4 core care pathways:

Referral and Review

This team incorporates the front door into the service and will seek to identify people with a social care package who have the potential to live a more independent life. The team will take a risk-based approach to put plans in place to provide the right level of support to enable skills development and to ensure they have access to suitable accommodation.

Preparing for Adulthood

This team will focus on 14+ age group and will initially get involved with support planning in an advisory capacity. The team will build relationships with the young person, schools, parents, Hackney Learning Trust, Hackney Ark and other stakeholders such as those involved in children's health services and continuing healthcare (CHC). By getting involved early the team will ensure that young people transition safely and smoothly from children's services into adults services.

On-going Support

This team will provide regular on-going support to help people manage their long-term conditions. In other words, 'case working' for service users with a variety of needs who require continuous intervention and/or monitoring beyond a period of 3 to 4 months. These service users will not be deemed capable of stepping down or 'moving on', because of the

inherent complexities surrounding their needs. Cohorts will include continuing healthcare cases (CHC), long-term complex work involving the Court of Protection, people with complex family situations, people whose situation does not tend to remain stable for long periods of time.

Intensive Support

This team will support service users who have a learning disability with co-morbid mental illness and / or behaviours which challenge. These service users are likely to include:

- Those with a chronic mental illness who are subject to the Care Programme Approach (CPA) or require assertive outreach.
- Those who have had a recent mental health admission either via mainstream or specialist services.
- Those who have had recent contact with Forensic Psychiatry services or who are currently inpatients detained under the Mental Health Act (1983).
- Those who urgently require assessment, diagnosis and intensive treatment for an acute presentation of mental ill health or a behaviour which challenges.

EXPECTED OUTCOMES

1. People should be supported to have a good and meaningful everyday life - through access to activities and services such as education, employment, social and sports/leisure; and support to develop and maintain good relationships.
2. Care and support should be person-centred, planned, proactive and coordinated – with early intervention and preventative strategies based on bespoke solutions and keyworkers to coordinate and join up support.
3. People should have choice and control over how their health and social care needs are met – with information available in formats that is easily understood and with independent advocacy and personal budgets routinely offered as appropriate.
4. People should be supported to live in the community with support from and for their families/carers as well as paid support and care staff.
5. People should have choice about where and with whom they live – with a choice of housing including small-scale supported living, and the offer of settled accommodation.
6. People should be enabled to access mainstream NHS services so they can have they support they need e.g. Annual Health Checks, Health Action Plans, Hospital Passports etc. as appropriate.
7. People should be able to access specialist health and social care support in the community – via integrated specialist multi-disciplinary health and social care teams, available on an intensive 24/7 basis when necessary.
8. Where appropriate, people should be able to get support to stay out of trouble, with reasonable adjustments aimed at reducing or preventing anti-social or ‘offending’ behaviour.

9. When their health needs cannot be met in the community, people should be able to access high-quality assessment and treatment in a hospital setting, staying no longer than they need to, with pre-admission checks to ensure hospital care is the right solution and discharge planning starting from the point of admission or before.

KEY SERVICES EXCLUDED FROM THIS AGREEMENT

Council Services outside the scope of this agreement but a key aspect of the local service system include:

Voluntary and community services

A range of voluntary sector and community groups funded to promote learning disabilities and deliver a community network model of service delivery.

Housing and housing related support services

The Council provides statutory housing services and works in partnership to provide housing advice and support residents in housing need, including those with mental health needs.

Public Health and Targeted preventative services

The Council has the lead responsibility for public health management and commissions a portfolio of services to promote health. A range of targeted preventative services are provided to meet the needs of residents at a high risk of needing acute and long-term health and care services.

SCHEDULE 3b

Role of ILDS Professionals

All staff will aim to:

- Transform care and support
- Ensure well-being and promote human rights
- Build community capacity by promoting independence
- Reduce unnecessary hospital admissions
- Ensure consistency of care
- Utilise best practice

ROLE OF SOCIAL WORKERS

Social work should focus on the links between the individual, their health and wellbeing and their need for relationships and connection with their families, community and wider society. In particular, this means:

1: Person-centred practice

Social workers should enable people to access the advice, support and services to which they are entitled. They should coordinate and facilitate practical and emotional support, and discharge legal duties to complement people's own resources and networks so that all individuals, carers and families can exercise choice and control. They should support individuals to make their own decisions, especially where they may lack capacity and meet individual needs and aspirations in personalised ways. This includes using the individual's existing networks of support and working co-productively to promote self-determination, community capacity, personal and family reliance, cohesion, earlier intervention and active citizenship.

Social workers should also engage with and enable access to advocacy for people who may require help to secure the support and care they need due to physical or mental ill-health, sensory or communication impairment, learning disability, mental incapacity, frailty or a combination of these conditions and their physical, psychological and social consequences.

2: Safeguarding

Social workers must be able to recognise the risk indicators of different forms of abuse and neglect and their impact on individuals, their families or their support networks and should prioritise the protection of children and adults in vulnerable situations whenever necessary. This includes working with those who self-neglect. They must take an outcomes-focused, person-centred approach to safeguarding practice, recognising that people are experts in their own lives and working alongside them to identify person centred solutions to risk and harm.

Social workers should understand and apply in practice personalised approaches to safeguarding adults that maximise the adult's opportunity to determine and realise their desired outcomes and to safeguard themselves effectively, with support where necessary.

3: Mental capacity

Social workers must have a thorough knowledge and understanding of the Mental Capacity Act (MCA) and Code of Practice and be able to apply these in practice. They must always begin from the presumption that individuals have capacity to make the decision in question.

Social workers should understand how to make a capacity assessment, the decision and time specific nature of capacity and hence the need to reassess capacity appropriately. They should also know when and how to refer to a Best Interest Assessor.

Social workers have a key leadership role in modelling to other professionals the proper application of the MCA. Key to this is the understanding that the MCA exists to empower those who lack capacity as much as it exists to protect them. They must balance the need to keep people safe while recognising and valuing the right of all individuals to express their own lifestyle choices.

4: Effective assessments and outcomes-based support planning

In undertaking assessments, social workers must be able to recognise the expertise of the diverse people with whom they work and their carers, and apply this to develop personalised assessment and care plans that enable the individual to determine and achieve the outcomes they want for themselves.

They must ensure the individual's views, wishes and feelings are included as part of their full participation in decision making, balancing this with the wellbeing of their carers. Social workers should demonstrate a good understanding of the social model of disability and of human development throughout life and demonstrate a holistic approach to the identification of needs, circumstances, rights, strengths and risks.

In particular, social workers need to understand the impact of trauma, loss and abuse, physical disability, physical ill health, learning disability, mental ill health, mental capacity, substance misuse, domestic abuse, aging and end of life issues on physical, cognitive, emotional and social development both for the individual and for the functioning of the family. They should recognise the roles and needs of informal or family carers and use holistic, systemic approaches to supporting individuals and carers. They should develop and maintain knowledge and good partnerships with local community resources in order to work effectively with individuals in connecting them with appropriate resources and support.

5: Direct work with individuals and families

Social workers need to be able to work directly with individuals and their families through the professional use of self, using interpersonal skills and emotional intelligence to create relationships based on openness, transparency and empathy. They should know how to build purposeful, effective relationships and be capable of communicating effectively with

people with specific communication needs, including those with learning disabilities, dementia, people who lack mental capacity and people with sensory impairment.

6: Professional ethics and leadership

Social workers should be able to explain their role to stakeholders, particularly health and community partners, and challenge partners constructively to effect multi-agency working. They should contribute to developing awareness of personalisation and outcome-based approaches to improving people's lives. They should be able to work collaboratively to manage effectively the competing interests of all stakeholders and be able to manage the inherent tensions where there is a dual role of care and control.

They should feedback the views and experiences of clients and their colleagues to contribute to the continued improvement of services, policies and procedures within the organisation. They must be able to recognise and address poor practice and systemic failings which put people at risk, whether in their own organisation or the organisations and institutions with which they are working, making appropriate use of whistle-blowing procedures.

[source: *Knowledge and Skills Statement for Social Workers in Adult Services*, DoH (2015)]

ROLE OF PSYCHIATRISTS

1: Diagnosing and treating mental health problems

People with an intellectual disability have high rates of mental health comorbidity and epidemiological studies have suggested a prevalence rate of 31–41%. Specialist health support for people with intellectual disabilities and/or autism is required for a range of needs as varied as:

- communication
- speech and eating difficulties
- severe mobility or postural difficulties
- physical disabilities
- psychological and psychiatric difficulties
- challenging behaviour

Psychiatrists play a key role in delivering/coordinating the specialist health support because of the nature of their medical training, which enables them to integrate biological, psychological and social elements of healthcare into care packages to manage and alleviate mental illness and to understand the complex interactions between mental and physical health and social/environmental factors.

Psychiatrists in intellectual disability services are expected to:

- Work with other professionals in mainstream services to help them understand the mental and physical health needs of people with intellectual disabilities and support them in working with them. This may include working with colleagues in mainstream mental health or forensic services to ensure that people receive a joined up service. Roles include providing joint assessments, formulations and interventions, consultations, reflective practice, and training thus facilitating the planning of appropriate treatments, based on a formulation.

- Have a person-centred approach with a focus on the recovery and enablement models of care.
- Promote the safety of patients, carers and the public through robust risk management plans with adherence to guidelines and policies on positive risk taking, safeguarding children and vulnerable adults.
- Be able to lead, work in and demonstrate a thorough understanding of a biological, psychological and social formulation with clearly defined multidisciplinary professional input into care plan which encompasses pharmacological, psychological, behavioural and social management strategies based on knowledge from the current evidence base and best practice guidance.
- Advise on the use of psychotropic medication where it is indicated. This can either be for mental illnesses or mental disorders with well-defined symptom clusters that have the evidence base supporting medication use.
- Work with the multi-disciplinary team to develop an effective crisis and contingency (which includes advance statements) and a personal safety plan to support the person within their community.
- Work with the multi-disciplinary team to evaluate the effectiveness of the care plans.
- Fulfil all legal requirements including those arising from the legislation on mental health, mental capacity, equality and human rights.
- Undertake supervision of and reflection to other psychiatrists and other health and social care professionals.
- Work with families and paid staff to provide effective support.
- Participate in the CTR process both before admission and for people admitted to an inpatient setting.

Trained in the developmental aspects of psychopathology and its unique presentations, psychiatrists will not only facilitate the early detection and treatment of mental health disorders, but will also avoid the misidentification of non – psychiatric conditions as mental disorders. They have key skills which include clinical decision-making in multidisciplinary contexts, managing dynamics in team settings, professional development of colleagues, service improvement and strive for quality, ensuring equity of access and outcomes, an ambassadorial role for health services and an acceptance of wider roles outside the employing organisation, horizon scanning to anticipate developments in policy and practice and then encourage evolution in service delivery. Therefore psychiatrists can help Commissioners, Providers, Carers and People who use services on a range of issues.

They are expected to:

- Understand the range of health and social care needs of service users
- Recommend evidence based/informed and values-based support and interventions
- Ensure a person-centred, whole person approach to multidisciplinary working
- Establish patient/carer partnerships to facilitate joint learning, co-production and training
- Identify and address workforce skills gaps and to assist in enhancing skills and competencies of the multidisciplinary workforce including carers
- Liaison working with other professionals in primary care and mainstream services in a consultative and advocacy role

- Ensure the right to access to services is accompanied by the positive outcomes for this group
- Ensure a human rights approach with least restrictive options is implemented across the service model taking into consideration the relevant legislative frameworks related to equality, mental health and mental capacity.

2: Helping others to understand and deliver the 'golden threads'

The role of psychiatrists is to ensure equity of access and equity of outcomes for people with intellectual disabilities and/or autism, across their life span, when they come into contact with health and social care settings in hospitals or in the community, specialist or mainstream services.

- Quality of life – Psychiatrists are expected to work with peoples and systems, integrate biological, psychological and social elements of healthcare into care packages to manage and alleviate mental illness and to understand the complex interactions between mental and physical health, to help describe what this means for people with behaviour that challenges, ensuring that people live, wherever possible, in the community, that they have fulfilling lives and that they are able to express and achieve their hopes and aspirations.

- Keeping People Safe – Psychiatrists have a key role in balancing people's rights and safety, helping others to understand and take positive risks.

- Choice and Control – Psychiatrists should act as professional advocates for people in having choice and control over decisions regarding their life. Psychiatrists are expected to help others to understand the Mental Health Act 1983, Mental Capacity Act 2005 and Equality Act and ensure that they are implemented in line with the Human Rights Act. This includes acting as Responsible Clinicians for patients detained under the Mental Health Act and undertaking capacity assessments and working with others with regard to Best Interests decisions.

- Support and Interventions – Psychiatrists are expected to keep up to date with current practice in the assessment and management of behaviour that challenges (including offending behaviour) and mental health problems in people with intellectual disabilities. They are expected to have a holistic understanding of the complex interactions between mental health, physical health and social factors and must be able to support formulating and implementing multi-disciplinary and multi-modal care plans which incorporate pharmacological, psychological, behavioural and social therapies.

- Equitable Outcomes – The principle of equity of access to mainstream services is meaningless without equity of outcome. Psychiatrists should work with mainstream providers to support them to not only make reasonable adjustments, but also ensure they have access to the required specialist skills set if needed that are important to ensure positive outcomes.

3: Promoting Cultural change and delivering the National Transformation Plan

Psychiatrists have a crucial leadership role to play in delivering the National Transformation Plan. This ranges from clinical decision-making in multi-disciplinary contexts which aligns with the service model, managing dynamics in team settings, professional development of

colleagues, service improvement and strive for quality, ensuring equity of access and outcomes, an ambassadorial role for health services and an acceptance of wider roles outside the employing organisation, horizon scanning to anticipate developments in policy and practice and then encourage evolution in service delivery.

They are expected to:

- Challenge and be challenged about care and support that is not delivered in line with up to date guidance and best practice and that does not address health and social care needs in a holistic manner.
- Challenge and be challenged about care and support that is institutional and inappropriately controls and restricts the person.
- Challenge and be challenged about systems that hinder effective multidisciplinary and/or multiagency working.

[Source: *Safe, sustainable and productive staffing: An improvement resource for learning disability services,* NHSE National Quality Board (January 2018)]

ROLE OF PSYCHOLOGISTS

Clinical psychologists provide a unique contribution to the aim of specialist learning disability services which is to support mainstream practice and directly serve those with the most complex needs (DH, Commissioning Specialist Adult Learning Disability Health Services, 2007).

Psychologists are trained to understand human behaviour within the context of the person and their environment. They are expected to synthesise information and to work proactively in complex organisational situations with some of the most complex service users. Clinical psychologists draw on a number of different theories and areas of research to guide their work. The core skills of all psychologists are assessment, formulation, intervention, service development, evaluation and research.

Psychologists have a significant part to play in bringing about innovation and change management at team and organisational levels; this is brought about through the breadth of clinical expertise and training, knowledge of the evidence-base and skills at influencing systems.

Psychologists have a key role to play in a number of different areas within Learning Disability Services dependent on the needs of the local community, commissioners and the service itself. These primarily include:

- The delivery of psychological therapy and interventions for mental health, behavioural and systems issues in line with recommended guidelines (NICE), policy or legislation and adapted for the LD population where necessary across a range.
- An ability to provide individualised assessment of the person across the range of mental health issues and adapt common psychological therapies as recommended by NICE to make them accessible to people with cognitive impairments.
- Contribute to multidisciplinary approaches to relapse prevention, including contributing to the development of risk management frameworks.
- Contributing to service pathways in relation to mental health both within and across MH and LD services.

- To work with complex case presentations, including individuals with multiple disabilities and/or complex health needs through consultation, clinical formulation and delivery of evidence based practices to meet any ongoing potential needs.
- Providing, and supporting others to provide, a diagnosis of a Learning Disability and Autism through the undertaking of recommended cognitive and adaptive behaviour assessments and/or clinical judgement where necessary.
- The development and delivery of teaching and training to social care staff and other professionals (e.g. GPs, CTPLD staff, CMHT staff, etc.) in the local area ith regards to LD and Autism as well as provide leadership in service development and contribute to the development of wider local strategy and service provision for people with an ASC and LD.
- Providing post diagnostic support from those with LD and Autism which may include assessment and evidence-based psychological interventions for any additional challenging behaviour, mental health problem or in other areas of need often associated with this group (e.g. understanding and use of social skills, understanding of relationships, etc.).
- The undertaking of specialised assessment of capacity in relation to a number of different decisions (e.g. Marriage, treatment, where to live, managing money, consent to sexual relationship etc.) including those required for court proceedings. Providing training to frontline staff on capacity issues as well as provide supervision and training of other staff who need to consider capacity issues Contribute to the development of care pathway for capacity assessment within the service.
- Contributing to the development of the local dementia strategy and the development of care pathways and protocols for delivery of care. Leading on clinical assessments which utilise specialised cognitive assessments where appropriate to contribute to the overall diagnosis of Dementia, including proactive baseline assessments for those at higher risk. To provide individualised assessment of the person leading to psychological formulation and which can contribute to differential diagnosis where appropriate. Psychologist can offer specific evidence-based interventions for individuals and services as well as broader training and consultation for staff, the local community and to carers
- Supporting team development and functioning through leaderships, consultation, supervision and training. This includes helping to achieve the best design and operation for teams, effective individual service planning, peer consultation and support processes, and reflective practice.
- Supporting commissioners and service managers to adopt best practice guidance, local and national policy and relevant legislation into service structures and delivery
- Developing links with other mental health services across the life span (e.g. children's, older adult) and across settings (e.g. community and hospital) to enable equal access to services and transition between services.
- Supporting access to mainstream services in line with national policy and relevant legislation through supporting an understanding of the needs of individuals with and LD and Autism, consultation to help manage complex presentations, including behaviours which challenge, and to consider key issues such as capacity and consent.
- Community engagement and teaching and training to help support develop the understand and needs of individuals with learning disabilities and autism.
- Psychologist have a key role in supporting and delivering recommendations and guidance for supporting those who's behaviours can challenge (e.g. Positive and Proactive Care, Winterbourn View, Service Model). They have a key role in implementing recommended approaches such as Postive Behavioural Support (PBS) and other psychological interventions to promote cultural change within service

providers and statutory organisations with the aim of improving the quality of life for service users.

Other roles & responsibilities include:

1: Assisting Commissioners, Providers, Carers and People who use services to understand the principles underpinning the Service model. Clinical psychologists have key skills that can help commissioners, providers, carers and people who use services to:

- Understand the complexity of the needs of the group served by the Service model
- Translate the evidence base for support and interventions into service descriptions
- Provide visionary leadership across the local system including leading on defining and delivering positive behaviour support (PBS), training others in PBS and ensuring that PBS is being delivered properly in services.
- Ensure that a Human rights based approach underpins all aspects of service delivery
- Identify and assist in training, consultation and support to all parts of the workforce
- Work with and, where needed, facilitate co-production work with people with learning disabilities and their families
- Use their psychological skills to assist the system to reflect and learn

2: Helping others to understand and deliver the 'golden threads' Clinical psychologists have the expertise and understanding of helping working to deliver these golden threads in services that they are working for and with.

- Quality of life – clinical psychologists are expected work within the system to help describe what this means for people with behaviour that challenges, ensuring that people live, wherever possible, in the community, that they have fulfilling lives and that they are able to express and achieve their hopes and aspirations.

- Keeping people safe – clinical psychologists have a key role in helping others to understand and take positive risks for people balanced by a need to protect the person and others from potential harm.

- Choice and control – clinical psychologists should act as professional advocates for people in having choice and control over decisions regarding their life. Clinical psychologists are expected to help others to understand and implement the Mental Capacity Act, including undertaking thorough capacity assessments and working with others with regard to Best Interests decisions.

- Support and Interventions – clinical psychologists are expected to have a thorough understanding and competence in implementing positive and proactive Care – ensuring that they and others recognise and challenge care that is not provided in the least restrictive manner – including the use of physical and chemical restraint and low level blanket restrictions that deny people choice and control. Having behaviour that challenges in itself restricts people's lives.

- Equitable outcomes – clinical psychologists should work with mainstream providers to support them to make reasonable adjustments to meet the psychological needs of people with learning disabilities.

3: Delivering the specialist health support

Clinical Psychologists are expected to play a key role in delivering the specialist health support required for people with learning disabilities who display behaviours that challenge. These roles will include working with other professionals to:

- Support to access mainstream services
- Work with mainstream services to develop their ability to deliver individualised reasonable adjustments
- Support to commissioners in service development and quality monitoring
- Delivery of direct assessment and therapeutic support

Clinical psychologists are expected to:

- Work with other professionals in mainstream services to help them understand the needs of, and support them in working with, people with learning disabilities – this may include working with colleagues in mainstream mental health or forensic services to ensure that people receive a joined up service. Roles may include providing joint assessments, formulations and interventions, consultations, reflective practice, and training.

- Be able to lead, work in and demonstrate a thorough understanding of a positive behaviour support framework.

- Work with the multidisciplinary team to undertake timely psychological assessments of peoples' behaviour that challenges based on knowledge from the current evidence base. The range and depth of assessment will depend on the presenting problem, but should not leave the person or others in the system at risk while being undertaken. The assessment should involve the person and their circle of support and all key stakeholders.

- Work with the multidisciplinary team to use the information from the assessment to develop a single formulation which in turn informs the person's positive support plan and the range of interventions that need to be undertaken in the short, medium and longer term. Assessments and Interventions should be in line with NICE guidance and Positive and Proactive Care, promoting reduction in physical and chemical restraint.

- Work with the multidisciplinary team to develop an effective crisis and contingency plan to support the person within their community.

- Work with the multidisciplinary team to evaluate the effectiveness of the positive support plan.

- Undertake supervision and reflection to other psychologists, behaviour workers and other health and social care professionals.

- Work with families and paid staff to provide effective support.

- Participate in the CTR process both before admission and for people admitted to an inpatient setting

4: Promoting cultural change and delivering the national transformation plan Clinical psychologists are expected to:

- Show visionary and transformational leadership across the local system including leading on defining and delivering PBS, training others in PBS and ensuring that PBS is being delivered properly in services.

- Challenge and be challenged about care and support that is not delivered in the least restrictive manner.
- Challenge and be challenged about care and support that is institutional and inappropriately controls and restricts the person.
- Challenge and be challenged about systems that hinder effective multidisciplinary and/or multiagency working.

Clinical psychologists will work in a range of settings including NHS, Social Services and private and voluntary sector. They may work within a range of teams including intensive support teams.

5: Ensuring competencies of psychologists

Training courses for clinical psychologists must ensure that trainees complete their training with the necessary competencies in working with people with learning disabilities and/or autism within a positive behaviour support framework. Clinical psychologists are expected to be and remain competent in the use of positive and proactive care.

[Source: *Commissioning Clinical Psychology Services for Adults with Learning Disabilities*, British Psychological Society (2011)]

ROLE OF SPECIALIST COMMUNITY LEARNING DISABILITIES / PSYCHIATRIC NURSES

Learning disabilities / Psychiatric nursing is a distinct strand of nursing with its own educational framework, which is tailored and specialised. Some are qualified in Learning Disability and / or Mental Health Nursing. They are a fundamental component of Multidisciplinary Teams and work with other professionals, both private and voluntary sector, clients, carers and / or relatives. They have links with Primary and Secondary care services.

LD/ Psychiatric Nurses also work with some providers who may find it difficult to meet service users' needs. They provide a comprehensive and seamless person centred service taking into account service users' needs and diverse background.

Learning Disability Nurses:

- Undertake comprehensive / specialists [nursing, mental health, risk assessments, CPA.NHS Continuing Healthcare [CHC] assessments of health and social care needs
- Develop ,implement, monitor and review person centred care plans, CHC, Health Action Plan [HAP], hospital passports
- Complete NHS CHC Check list, DSTs and Assessments
- Commissioning care packages and care Co-ordination, annual reviews or when individuals' circumstances change.
- Collating and maintaining accurate data relating to NHS CHC cases
- Collate and maintain the NHS CHC register for service users on fully funded CHC care packages
- Provide 1:1 treatment plans to make service users feel better and / or cope

- Arrange and co-ordinate service users' care e.g. Outpatient clinic and administer depot injections.
- Administer other non-depot injections and special medication and monitor compliance and side effects.
- Manage and monitor service users on CTRs [Community Treatment Reviews]
- Hospital avoidance for service users enduring mental illness.
- Monitoring the effects/ side effects of Clozapine medication and liaise with Clozapine Clinic Team
- Monitoring the effects/ side effects of Lithium medication to reduce the risk of Lithium poisoning
- Mental and physical health monitoring
- Home visits – announced/ unannounced
- Out of Borough visits
- Work collaboratively with health, social care and education professionals Locally and Out of Borough
- Refer to other specialist if needed
- GP liaison
- Maintain close working links with Hospital LD Liaison Nurse; supporting the admissions and discharge pathway and / or into acute hospital settings.
- Provide advice and support to primary and secondary care providers to make reasonable adjustments
- Provide nursing care and interventions to maintain and improve health and promote well-being
- Navigate and support service users to access primary care services
- Reducing fear of health checks through desensitisation
- Enable equality of access and outcomes within health and social care services
- Provide advice, education and support to service users and their carers on various health topics e.g. epilepsy, diabetes, sexual health, medication management, health action planning and health facilitation, mental health and wellbeing.
- Provide education and support to help service users make healthy choices, develop healthy lifestyles , identify and avoid risks
- Facilitate healthy living groups i.e. mindful yoga and to access other healthy living groups e.g. smoking cessation. gym
- Working with complex cases relating to children and / or adult safeguarding and protect the rights of people with learning disabilities when they are vulnerable and in need of additional support.
- Provide regular updates to joint LD commissioners for service users on the at risk register
- Advocate for service users and their carers paid/ unpaid
- Liaise closely with local universities to negotiate student nursing placements
- Facilitate nursing students on Placement
- Contribute towards education and teaching programmes in house and / or externally

[Source: *Safe, sustainable and productive staffing: An improvement resource for learning disability services*, NHSE National Quality Board (January 2018)

ROLE OF OCCUPATIONAL THERAPISTS

Occupational Therapy is a profession founded on the belief that occupation is essential to good health and wellbeing. "Occupation" as a term refers to practical and purposeful activities that allow people to live independently and have a sense of identity. This could be essential day-to-day activities such as:

- Self-care e.g. dressing, washing, cooking
- Being productive e.g. participating in education, work, volunteering or doing chores around the home
- Leisure e.g. socialising with friends, belonging to a group, participating in hobbies

Occupational deprivation affects both physical and psychological health. This can be a particular problem for people with learning disabilities who are more likely to experience social isolation, dependence on others to plan and complete activities and poor access to services (Department of Health, 2001). A lack of meaningful occupation or imbalance in occupation can contribute to behaviours that challenge and can have an impact on health and wellbeing.

Specialist occupational therapists with their expertise in facilitating occupational performance and occupational participation provide practical support to empower people to maintain, restore, or create a beneficial match between an individual's abilities, the demands of their occupations and the demands of the environment, in order to maintain or improve their functional status and access to opportunities for meaningful participation. This can involve helping people with learning disabilities to access occupations; learn new independent living skills; adapting activity, equipment, environment or materials in the places where they live and work to ensure occupations are graded to the person's interests, roles, routines and skills.

Specialist occupational therapists should ensure that:

- Access, choice and variety in occupations are a core provision and that occupations are adapted to facilitate inclusion of people with a range of interests, skills, health needs and abilities.
- Patterns of activities across the day and week (including evenings and weekends) include a range of opportunities relating to self-care, productivity and leisure.
- Where challenges to occupation have been identified that opportunities for interaction, engagement and involvement in meaningful occupations are created, both with others and independently.
- Plans are in place to address occupational needs that acknowledge the impact of the person's needs, physical space, social context and components of the occupation.

- Records clearly describe the occupations a person wants to, needs to, or is expected to do and will be the immediate focus for the person and staff.
- Occupational strengths and needs are identified in collaboration with the service user.

Occupational Therapists should

- Deliver personalised assessments and interventions that focus on individuals' occupational strengths, needs and barriers to occupation. Barriers to occupation can be either 'personal' (cognitive and/or physical) and/or 'environmental' (social and/or physical). People are intrinsically active and creative, needing to engage in a balanced range of activities in their daily lives in order to maintain physical and mental health. Occupational therapy assessments uniquely ascertain the impact of someone's learning disability on their occupational performance, highlighting how the learning disability affects their life and engagement in occupations that are important to them. This can include specialist assessment of the impact of sensory processing difficulties and/or mental illness on behaviours that challenge, identifying triggers and delivering interventions to improve the individual's occupational engagement and participation.
- Support an understanding of the relevance and role of occupation in health and well-being with specialist skills in activity analysis, assessment of function, collaborative goal setting and evaluation. By supporting individuals to access a range of meaningful occupations, particularly in relation to leisure, productivity and self-care, the impact of complex health and social issues such as mental illness, physical disabilities, sensory processing difficulties, behaviours that challenge and social isolation can be reduced, issues surrounding occupational deprivation addressed, quality of life improved and health inequalities reduced.
- Utilise a wide-ranging specialist assessment process with an aim to improve individuals' functional abilities, and develop existing and new skills. Occupational therapists contribute to the development of correct care packages by working closely with other health and social care services. This is particularly important at times of life transitions, for example from child to adult services, moving from family home or residential services to supported living and as health needs change such as with the onset of dementia.

[Source: *Safe, sustainable and productive staffing: An improvement resource for learning disability services,* NHSE National Quality Board (January 2018)]

ROLE OF PHYSIOTHERAPISTS

Specialist physiotherapists promote physical health and mental wellbeing and are expert in assessment, measurement and analysis of movement and function (HCPC.2013) to ensure effective evidence-based practice to prevent and reduce the incidence and impact of complex and multiple physical and sensory disabilities.

Specialist physiotherapists working with people who display behaviour that challenges are required to uphold the 'golden threads' of - quality of life, keeping people safe, choice and control, support and interventions and equitable outcomes.

Specialist physiotherapists in the field of learning disabilities are expected to:

- Provide person-centred assessments and interventions.
- Play a key role in delivering the specialist health support required by people with a learning disability.
- Facilitate and support people with a learning disability to access mainstream physiotherapy and other health services and obtain positive outcomes. They may have difficulty accessing mainstream services due to behaviours that are seen as challenging, communication difficulties, complex physical presentations/comorbidities, or mental health issues. Support to mainstream services may include joint assessments, interventions, training and health advocacy.
- Work with mainstream physiotherapy services to develop their ability to deliver individualised reasonable adjustments.
- Work with members of the multidisciplinary team, the person's circle of support and all key stakeholders to deliver appropriate and timely interventions.
- Facilitate people with a learning disability and physical disabilities to access community based sport and leisure facilities in line with the public health agenda.
- Develop and implement long-term physical management programmes and educate and support families and paid staff in the delivery of these programmes. These should include but are not limited to the following areas:
  - 24 hour postural management
  - Community level respiratory management
  - Rehabilitation from acute injuries and/or conditions
  - Management of mobility problems
  - Falls prevention and intervention
- Liaise and work collaboratively with the relevant multidisciplinary teams in the planning and support of the young person and their family during the transition process from children's to adult services.
- Be visionary and provide leadership in the interpretation and implementation of the transformation agenda in relation to services for people with a learning disability and physiotherapy services in particular.

ROLE OF SPEECH AND LANGUAGE THERAPISTS

Communication skills are essential for being able to express needs and preferences and ultimately to making choices and leading an independent life. Speech and language therapists have a unique role in identifying the social communication characteristics of importance to diagnosis, contributing to differential diagnosis and facilitating identification of retained abilities and comorbidities e.g. hearing loss

Interventions by speech and language therapists are set within a social model driven by principles detailed in Valuing People framework, and they are integral members of any multi-disciplinary team supporting children, adults, their family and carers because:

- Difficulties with social communication is a predominant feature in reducing access to education, employment and social integration.

- Communication difficulties are associated with increased prevalence of challenging behaviour.
- Swallowing disorders are associated with increased ill health, chest infections and reduced survival rates.
- Speech and language therapists have a key role in educating/training others involved in the care of those with learning disabilities including the family, health, education and social care staff. There is research evidence of the positive impact of speech and language therapists conducting training packages on the behaviour of others in promoting communication with persons with learning disabilities.
- There are critical periods in the life of a person with learning disabilities where additional speech and language therapy intervention may be needed e.g. moving between schools, death of a member of the family etc.
- There is evidence that the use of augmentative and alternative methods of communication are effective in facilitating communication and do not reduce speech production capabilities.
- As part of all service delivery there is emerging practice and developing roles. Within Learning Disability this might include building capacity in other services and the wider community and helping services to make reasonable adjustments.

The key principles of the RCSLT position paper on Speech and Language Therapy Provision for Adults with Learning Disabilities are:

1) Speech and Language Therapy service delivery is committed to the promotion of independence, choice, inclusion and civil rights.

2) Speech and Language Therapy service delivery considers communication needs in the context of a social model of disability.

3) Speech and Language therapists are committed to delivering their services in line with the personalisation agenda.

4) The practical delivery of Speech and Language Therapy services to adults with learning disabilities is in line and in partnership with local policies, resources, and priorities.

5) All modalities of communication are valued, respected and promoted by Speech and Language Therapists.

6) Speech and Language Therapy service delivery maximises service user involvement at all levels.

7) A collaborative approach to service delivery across agencies, professional groups and also across the lifespan of the people with learning difficulties is essential.

In order for Speech and Language Therapists to address the communication barriers faced by people with learning disabilities, they must deliver their services within a broad context and work closely with other health, education and social care professionals. A variety of approaches are likely to be used, and these may include one or more of the following:

- Assessment and evaluation
- Producing a formulation based on this evaluation
- Devising a plan with clear objectives

- Advice/consultation/ co-working with others
- Training/ teaching/ transmitting information
- Coaching/ enabling/ resourcing
- Change management
- Service development

[Source: *Resource Manual for Commissioning and Planning Services for SLCN: Learning Disability*, Royal College of Speech and Language Therapists (2009)]

ROLE OF DIETITIAN

Tailored diet therapy is fundamental determinant of an individual's independence, quality of life and clinical outcomes. The dietitian's role within the multidisciplinary team is to provide nutrition support for adults with learning disabilities whose ability to feed themselves or absorb nutrients is compromised by physical means, including dysphagia, compromised posture or manual dexterity, disease process amongst others, and social means.

Inadequate nutrition and hydration support are commonly associated with preventable hospital admission; 1 in 3 patients are admitted to hospital with malnutrition, or at risk of malnutrition. Current spend on oral nutritional supplements across the borough exceeds the spend on dietetic provision and is cost-ineffective related to inappropriate and prolonged prescription. Diabetes and obesity prevalence in Hackney is disproportionately high, notably in marginalised and vulnerable groups within the borough.

The dietitian within the learning disabilities team is well-placed to ameliorate and prevent these issues, through providing specialist dietetic intervention:

- enteral nutrition support (tube-feeding) for patients with profound and multiple learning disabilities.
- oral nutrition support (prescribed nutritional supplements) for patients who may have dysphagia or compromised independence with nutrition.
- weight loss management for overweight and obese patients who are suffering comorbidities including diabetes risk and impaired mobility.
- group programmes on weight management and activity
- training programmes on tube care, and food fortification with dysphagia

Key stakeholders with whom the dietitian liaises:

- therapists, nurses, social workers, psychologists and psychiatrists within ILDS
- parents, relatives carers, support workers, day centre and care home staff
- GPs
- Nutrition nurses and Fresenius Kabi staff
- acute gastroenterology, neurology, dietetics and nutrition teams in and out of borough
- safeguarding teams

Key responsibilities:

- managing busy and dynamic caseloads to support dysphagia (tube-feeding and oral nutrition support) and weight management (obesity group and diabetes prevention)
- record intervention safely and communicate across sectors with multiple teams

- use alternative anthropometrics as part of assessment
- use nutrition-related biochemistry as part of assessment
- use clinical history, markers and observations as part of assessment
- provide tools/recording charts/advice/safe parameters and guidance plans for care-providers to enable sustainable dietary change
- liaise with feeding companies, nutrition nurses and GPs to provide appropriate nutrition products
- raise safeguarding concerns pertaining to nutritional neglect support teams to understand nutritional priorities for patients

SCHEDULE 3c:

Care Governance Matters

As the service host, Trust staff will be seconded to the London Borough of Hackney. Staff will be line managed by the service Team Managers (who may be health or social care professionals) on a daily basis. Professional supervision of social workers will be undertaken by the Council (partnership lead for social care) while clinical staff will receive professional supervision from the Trust (partnership lead for health).

Approved Mental Health Practitioners (AMHPs)

The Council is responsible for ensuring the warranting of AMHPs as well as ensuring there is adequate provision within the service. In addition, the Council will ensure that arrangements are place to provide a 24 hour service in order to respond appropriately to service user needs.

Best Interest Assessors under Deprivation of Liberty Safeguards – Mental Capacity Act 2005

As service host, the Council is responsible for ensuring that appropriate Deprivation of Liberty Safeguards and Best Interest Assessments (BIA) are carried out. In order that there are sufficient Best Interest Assessors staff from a range of professional backgrounds will be trained in BIAs and undertake these statutory assessments within local arrangements. The

arrangement for service provision will be routinely managed and co-ordinated by the Council's Safeguarding Team.

Client Affairs

All arrangements regarding the administration and protection of service users' money and property, including deputy and 'appointee-ships' will be the responsibility of the Council. All such matters should be referred to the Council's Client Affairs team, using the Council's procedures.

Safeguarding

Both partners are signatories to Hackney's multi-agency safeguarding policy, which provides a partnership framework. Trust staff managed by the Council will operate under the LBH multi-agency Protocol.

Clinical Governance & CQC Registration

Both the Trust and the Council will ensure the registration of provider services within the scope of this agreement in line with CQC requirements. The Trust and the Council will ensure there is a suitable framework and mechanisms in place in order to assure appropriate clinical governance. This will include the provision of assurance to the Learning Disability Partnership Management Group that services are providing safe and effective care and to external inspectors such as NHSLA, OFSTED and the Care Quality Commission.

SCHEDULE 4:

Human Resource Management and Governance

1. OVERVIEW.

1.1 The Trust shall make the Managed Staff available for the ILDS service, via secondment, pursuant to the attached Management Agreement. The policies as are agreed by the Partners from time to time to be applied by the Council to the Managed Staff for the duration of the Management Agreement or on such other terms as the Partners may agree from time to time. A full and up to date list of posts and post holders will be maintained by the Council and the Trust to provide clear record of Managed Staff.

1.2 The Partners agree that the Managed Staff will:

1.2.1 Remain in the employment of the Trust on their existing terms and conditions as varied to give effect to the making available arrangements; and

1.2.2 Be made available to the services pursuant to the Management Agreement.

1.3 Trust staff managed by the Council operate under the day to day line management of the Council but the NHS code of conduct applies. Professional supervision will be done through the Trust's Clinical Governance structures and procedures.

1.4 The Partners may consider at any time the suitability of the Management Agreement to fulfilling the aims and objectives of this Agreement.

2. RECRUITMENT AND STAFF ESTABLISHMENT

2.1 Recruitment to all the service's vacant and new posts, including temporary, agency and fixed term contracts, will be managed jointly. Council employed staff will be recruited in accordance with the Council's approval processes; Trust employed staff will be recruited in accordance with Trusts approval processes.

2.2 On approval, the service's management will work in partnership with the Trust's recruitment team to advertise and source applicants.

2.3 All changes to the service's establishment including transfer of staff between teams, change of management reporting lines must be agreed between the two parties. These changes should immediately be made by use of the appropriate Council's e-documentation that will then feed into the governance system.

2.4 If any member of Managed Staff resigns then the Council shall notify the Trust as soon as is reasonably practicable. The Trust's policies and procedures apply if managed staff contracts are terminated.

2.5 Following the Commencement Date and for the duration of this Agreement the Council shall:

2.5.1 Acknowledge that the management agreement as set out in Appendix 1 has been formally ratified;

2.5.2 Notify the Trust if the Council becomes aware of any act or omission by any member of Managed Staff which may constitute a material breach of their employment contract; and consult with the Trust as often as may be reasonably necessary in relation to the management of the Managed Staff.

2.6 During this Agreement, the Council shall take all reasonable steps to ensure the Managed Staff shall:

2.6.1 devote the whole of their time attention and skill to their duties for which they are made available to perform pursuant to this Agreement;

2.6.2 faithfully and diligently perform duties and exercise such powers as may from time to time be reasonably assigned to or vested in them; and

2.6.3 perform all duties assigned to them pursuant to this Agreement.

3. RECRUITMENT OF AGENCY STAFF

3.1 The service's management will consult with the Trust as often as may be reasonably necessary in relation to the recruitment of all agency staff covering clinical posts.

4. STAFF PERFORMANCE

4.1 Under-performance relating to Council staff will be managed in accordance with the relevant Council policies and procedures relating to conduct, capability, sickness absence, disciplinary and grievance. Under-performance relating to Trust staff will be managed by the Line Manager, in accordance with the Trust's policies and procedures.

4.2 Advice will be available from the Council's and the Trust's Human Resources staff.

5. SERIOUS INCIDENTS REQUIRING INVESTIGATION

5.1 In the event of a serious incident requiring investigation, the head of service or Director of Adult Services will consult with the Trust and agree appropriate action to be taken.

6. TRAINING AND WORKFORCE DEVELOPMENT

6.1 The Trust and the Council will, on an annual basis jointly identify, develop and review workforce development plans for social work staff and agree plans to reflect Continuing Professional Development registration requirements and local strategic workforce demands. The Head of Service and Clinical Leads will ensure that individual personal development plans are put in place for all service staff and staff will be supported to ensure continued professional development. The appraisal of Trust staff will be carried out by the Line Manager.

6.2 The Partners acknowledge and agree that all training specific to or relating to the service that is provided in-house by both Partners shall be made available to the staff of the other partner to attend, without any charge or cost to the other partner.

6.3 In the event that a Partner purchases external training through a third party provider or otherwise that is specific to or relating to the service, this training shall also be made available to the staff of the other Partner to attend, but where any such staff attend the training, the other Partner shall be required to contribute to the cost of the training proportionate to the number of its staff who confirm their intention to attend through their employer and actually attend the training, unless this requirement is wavered at the charging partners discretion.

6.4 The partners warrant that the staff that each party makes available for the service have all relevant qualifications to perform competently.

7. INDUCTION

7.1 All staff will be subject to the service's staff induction procedures.

7.2 Staff will also be referred to and participate in Trust induction activities as appropriate.

8. APPRAISAL/SUPERVISION

8.1 The Council's line management supervision policy will be used to prioritise and manage day to day operations. The Trust's Supervision and Appraisal policies to be followed for Trust staff.

8.2 Clinical supervision for Trust staff will be managed and provided by the Trust.

9. DISCLOSURE BARRING SYSTEM (DBS) AND RELEVANT PROFESSIONAL BODIES

9.1 The partners warrant that with respect to the staff which each party makes available hereunder, it has completed all pre-employment, employment and regulatory checks reasonably required of it as an employer and will share details of any outstanding check in relation to such staff.

9.2 In the event of an adverse DBS check, the Council and the Trust will undertake a joint risk assessment in relation to potential employment/ongoing employment. This will include failure on the part of the applicant to disclose relevant convictions on their application form.

9.3 DBS checks for new clinical staff and renewals will be processed by the Trust.

10. ORGANISATIONAL CHANGE OF SERVICES/STRUCTURES

10.1 Where there is a proposal to change services/structures affecting staff from the Trust both the Borough Director and the Director of Adult Services will work together to ensure that relevant organisational change processes will be implemented. Both partners unions must be notified in accordance with the procedures.

10.2 For any changes to services/structures affecting service staff the business case will be shared with Council staff and unions.

10.3 Changes to terms and conditions, including pay awards, policies and procedures will be notified to staff either by group/individual consultations or via email communication in accordance with the relevant employer procedures.

11. STAFF ENGAGEMENT AND CONSULTATION ARRANGEMENTS WITH TRADE UNIONS

11.1 The partners policy on agreed arrangements for Time off to attend Trade Union Meetings will apply to respective staff that are members of a recognised union. This includes time off to attend Trade Unions AGMs.

12. TUPE

12.1 Health clinicians are employed by the Trust but seconded to work in the Council's Children's and Adult Services directorate, because Hackney Council is the service host. The Partners do not consider or intend that the arrangements envisaged by or coming into effect as a result of this Agreement constitute a relevant transfer for the purposes of The Transfer of Undertakings (Protection of Employment Regulations 2006 (as amended) ("TUPE").

SCHEDULE 5:

Finance and Resources

1 Overview

1.1 This Schedule provides details of the budgets, premises, goods and services to be made available by the Partners and also outlines the key principles governing budget setting and accounting for its use.

2 Financial Arrangements

2.1 The Learning Disability Partnership Management Group (LDPMG) will confirm each financial year, in accordance with Clauses 9 and 12 of the Agreement, the budgets (agreed through each partner's budget setting process), financial procedures and arrangements for the operation of this Agreement for the following financial year, including all or any of the following:

- Use of specific grants and other income;
- Monitoring information and formats (including contract monitoring);
- Monitoring timetable;

- Information management systems & structures for collecting activity and finance information; and
- Accommodation arrangements for Services.

2.2 The Annual Budgets at Appendix 2 to this schedule will be reviewed and updated on an annual basis in accordance with Clauses 9 and 12 of this Agreement.

3 Financial Planning

3.1 The Budgets will be reviewed in accordance with Clause 12. This will take account of, but not be limited to the following:

- Demographic change
- Service enhancement or reduction
- Required efficiency / quality improvement
- Income streams and
- National Initiatives.

3.2 The Council's Chief Finance Officer (Section 151 Officer) and the Trust's Director of Finance will advise the appropriate deadline dates for the provision of such information.

3.3 In respect of financial planning and Budgets, each Partner will provide explanations, analysis and documentation to enable the other Partner to understand the basis of the planning assumptions and Budgets. This information will be made available at the same time as the Budgets are shared with the other Partner.

4 Budget Performance

4.1 The process for addressing forecast overspends/underspends and taking appropriate action will be managed by the LDPMG and the individual partners.in accordance with the Agreement.

5 Resource Monitoring

5.1 Each Partner will submit quarterly financial and staffing reports to the LDPMG as soon as possible after the end of each quarter, but in any event within 40 days of the end thereof, and an annual return following the end of each year in line with statutory and local deadlines and requirements.

5.2 Financial reports will provide (i) a breakdown of annual budgeted staffing, other costs and income, (ii) comparable amounts of expenditure and income incurred to date, (iii) comparable projected annual expenditure and income, (iv) projected annual spend variations in respect of staffing, other costs and income, and (iv) explanations of such variations which exceed 5% of budget and £10k.

5.3 Quarterly staffing reports will show which posts are filled permanently, which are filled by agency staff, and which are vacant. Actions to recruit permanent staff and fill vacancies will be reported. Quarterly sickness absences will also be reported.

6 Access to Financial Information

6.1 The Trust and the Council will make all relevant financial information and records available to each other, subject to any constraints imposed by Clause 21 of the Agreement and commercial confidentiality, and will provide full explanations, exemplifications and advice in response to any reasonable question or request from the other Partner in respect of the Services. The Partners will ensure that financial and other information presented to the LDPMG is accurate and complete.

7 Construction of Budgets

7.3 The Council will bear responsibility for all costs associated with council employees while the Trust will bear responsibility for all costs associated with ELFT employees which are managed by the service. Both partners will ensure that their allocated budgets covers these costs.

7.4 Appendices 2 and 3 sets out the Budgets and Staffing of the Council and the Trust and salary costs will be subject to annual pay awards.

8 Resources available outside Partners budgets

8.1 The Partners shall ensure continued access to all resources outside the budgets detailed in Appendix 2 necessary for the purposes of this Agreement including the relevant central support services and IT systems. Use of these resources shall be subject to each of the Partner's own policies and procedures, notified to the other party from time to time.

9 Staff Numbers and Budget – Trust/LBH

9.1 Appendix 2 shows the total numbers of staff and budget contribution from for services provided, under the Section 75 agreement as at 1st January 2019. Salary budgets for health staff are provided on the basis of maximum and mid-point banding costings. Actual salary costs for clinical staff (excluding Psychiatry registrar post) will be recharged from the Trust to the Council on a quarterly basis.

10 Further detail on staff management and authorisation of spend 10.1 Further detail on staff including vacancies, salary grading/bands and professional qualifications will be held on HR systems within the Council and the Trust, with regular joint reporting to through the quarterly and annual review process.

11 Asset Register

11.1 An asset register will be kept in line with relevant ICT policies, providing a detailed breakdown of each partner's contribution and kept up to date in line with organisational changes. In summary:

11.2 London Borough of Hackney will provide desktops for both ELFT and LBH staff within the Hackney Service Centre.

11.3 LBH will also supply Laptops, Chrome Books and mobile phones to staff, dependent on individual need.

11.4 ELFT will provide desktops for both ELFT and LBH staff at St Leonards.

11. 5 ELFT will also supply laptops and mobiles phones to staff, dependent on need.

SCHEDULE 6:

Estates

1 Premises

1.1 The Council and the Trust shall provide or make available the premises, with the same support services and facilities management to those premises, that they provided before the Commencement Date, subject to either Party notifying the other annually of any required changes and the reasons for the changes.

1.2 The Council, in their capacity as service host, will take on the lease in order to ensure continued access to Block B, 2nd Floor consulting rooms at St. Leonard's Hospital, Nuttall St, London N1 5LZ, where ILDS clinicians operate their specialist clinics from Monday to Friday 9am to 5pm. These premises will be leased directly from NHS Estates.

1.3 The Council shall ensure ongoing access to the service's main office premises at Hackney Service Centre, 1 Hillman Street, London E8 1DY.

1.4 Contributing Budgets from the Trust and the Council as set out in Appendix 2 to this Schedule excludes the costs of IT systems and relevant corporate estate management costs. Premises-related costs such as furniture, equipment, stationary, printing, postage, telephone and mobiles are included in the Budgets.

1.5 Use of the premises shall be subject to each of the Partner's own policies and procedures, notified to the other party from time to time.

1.6 An estimated annual rental cost of £80k for the use of St. Leonard's facilities has been provided by the previous leaseholder - Homerton University Hospital Trust. The final actual cost will be agreed with NHS Estates as part of the negotiations around the new leasing arrangements.

SCHEDULE 7a:

1 Information Technology Systems and Infrastructure

1.1 As a fully integrated health and social care service, Integrated Learning Disability Service (ILDS) staff need access to information and systems managed by both London Borough of Hackney (LBH) and East London Foundation Trust (ELFT). This will require The Council and the Trust's IT teams to collaborate effectively so that Integrated Learning Disabilities Service are able to operate successfully.

1.2 The Council and the Trust shall make the necessary arrangements to make this possible and ensure that the service's needs are met.

1.3 The Trust, in their capacity as health lead, will be responsible for enabling remote access to health care records and other information managed by them that is needed by ILDS.

1.4 The Council, in their capacity as service host, will be responsible for enabling access to social care records and other information managed by them that is needed by ILDS.

1.5 The Council and the Trust will put in place Lead IT contacts to enable collaboration to ensure the needs of ILDS are met. The arrangements agreed will be captured in a Memorandum of Understanding (MoU) that will be maintained and reviewed periodically by the designated IT Leads. The MoU will detail how the Trust and the Council will work together and include what each partner is contributing.

1.6 The Partners are committed to co-operating with one another under this Agreement and agree to:

1.6.1 keep one another informed;

1.6.2 liaise effectively;

1.6.3 work together in good faith; and

1.6.4 be committed to the principles set out in this Agreement in relation to governance and financial management.

SCHEDULE 7b:

Data Protection

Definitions

"*Controller, data controller, processor, data processor, data subject, personal data, processing and appropriate technical and organisational measures*" - as per current Data Protection Legislation.

"*Data Protection Legislation*" - all legislation and regulatory requirements in force from time to time relating to the use of personal data and the privacy of electronic communications, including, without limitation (i) any data protection legislation from time to time in force in the UK including the Data Protection Act 2018 or any successor legislation, as well as (ii) the General Data Protection Regulation ((EU) 2016/679) and any other directly applicable European Union regulation relating to data protection and privacy (for so long as and to the extent that the law of the European Union has legal effect in the UK).

"*Permitted Recipients*" - The partners to this agreement, the employees of each partner, any third parties engaged to perform obligations in connection with this agreement.

"*Shared Personal Data*" - the personal data to be shared between the partners under this agreement.

1. Data Protection

1.1 Shared Personal Data. This clause sets out the framework for the sharing of personal data between the partners as data controllers. Each party acknowledges that one party (the Data Discloser) will regularly disclose to the other party (the Data Recipient) Shared Personal Data collected by the Data Discloser for the Agreed Purposes.

1.2 Effect of non-compliance with Data Protection Legislation. Each party shall comply with all the obligations imposed on a controller under the Data Protection Legislation, and any material breach of the Data Protection Legislation by one party shall, if not remedied within 30 days of written notice from the other party, give grounds to the other party to terminate this agreement with immediate effect.

1.3 Particular obligations relating to data sharing. Each party shall:

(a) Ensure that it has all necessary notices and consents in place to enable lawful transfer of the Shared Personal Data to the Permitted Recipients for the Agreed Purposes;
(b) Give full information to any data subject whose personal data may be processed under this agreement of the nature such processing. This includes giving notice that, on the termination of this agreement, personal data relating to them may be retained by or, as the case may be, transferred to one or more of the Permitted Recipients, their successors and assignees;
(c) Process the Shared Personal Data only for the Agreed Purposes;
(d) Not disclose or allow access to the Shared Personal Data to anyone other than the Permitted Recipients;
(e) Ensure that all Permitted Recipients are subject to written contractual obligations concerning the Shared Personal Data (including obligations of confidentiality) which are no less onerous than those imposed by this agreement;
(f) Ensure that it has in place appropriate technical and organisational measures, reviewed and approved by the other party, to protect against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

Not transfer any personal data received from the Data Discloser outside the EEA unless the transferor:

I. Complies with the provisions of Articles 26 of the GDPR (in the event the third party is a joint controller); and
II. Ensures that (i) the transfer is to a country approved by the European Commission as providing adequate protection pursuant to Article 45 GDPR; (ii) there are appropriate safeguards in place pursuant to Article 46 GDPR; or (iii) one of the derogations for specific situations in Article 49 GDPR applies to the transfer.

1.4 Mutual assistance. Each party shall assist the other in complying with all applicable requirements of the Data Protection Legislation. In particular, each party shall:

(a) Consult with the other party about any notices given to data subjects in relation to the Shared Personal Data;

(b) Promptly inform the other party about the receipt of any data subject access request;
(c) Provide the other party with reasonable assistance in complying with any data subject access request;
(d) Not disclose or release any Shared Personal Data in response to a data subject access request without first consulting the other party wherever possible;
(e) Assist the other party, at the cost of the other party, in responding to any request from a data subject and in ensuring compliance with its obligations under the Data Protection Legislation with respect to security, breach notifications, impact assessments and consultations with supervisory authorities or regulators;
(f) Notify the other party without undue delay on becoming aware of any breach of the Data Protection Legislation;
(g) At the written direction of the Data Discloser, delete or return Shared Personal Data and copies thereof to the Data Discloser on termination of this agreement unless required by law to store the personal data;
(h) Use compatible technology for the processing of Shared Personal Data to ensure that there is no lack of accuracy resulting from personal data transfers;
(i) Maintain complete and accurate records and information to demonstrate its compliance with this clause; and
(j) Provide the other party with contact details of at least one employee as point of contact and responsible manager for all issues arising out of the Data Protection Legislation, including the joint training of relevant staff, the procedures to be followed in the event of a data security breach, and the regular review of the parties' compliance with the Data Protection Legislation.

1.5 Indemnity. Each party shall indemnify the other against all liabilities, costs, expenses, damages and losses (including but not limited to any direct, indirect or consequential losses, loss of profit, loss of reputation and all interest, penalties and legal costs (calculated on a full indemnity basis) and all other reasonable professional costs and expenses) suffered or incurred by the indemnified party arising out of or in connection with the breach of the Data Protection Legislation by the indemnifying party, its employees or agents, provided that the indemnified party gives to the indemnifier prompt notice of such claim, full information about the circumstances giving rise to it, reasonable assistance in dealing with the claim and sole authority to manage, defend and/or settle it.

Data Subjects

- Integrated Learning Disability Service (ILDS) Service users
- Carers
- Advocates
- Providers
- Other professionals who are associated with the service user
- Non-caring family members

Categories of Personal Data

- Full name
- Date of Birth
- Language / Communication needs
- Current address

- Current telephone number
- Primary Support Reason
- NHS number
- Gender
- Financial Assessment information
- Carer details

Categories of Sensitive Personal Data

- Religion
- Sexuality
- Ethnicity
- Health Conditions
- Assessment details (required to purchase services)
- Allocated Unit (accurate start and end dates)
- Review completion outcomes
- Service packages
- Carers Assessment outcomes
- Safeguarding case outcomes
- A Data Recording Protocol for MH Teams – Draft
- Medical conditions
- Clinical diagnostic records
- Information about medication
- GP records/letters
- Safeguarding alerts/investigation findings
- Hospital discharge information
- Health and social care needs
- Services provided
- Court of Protection documentation

Processing purposes

- Service eligibility
- Clinical diagnosis
- Assessments
- Care planning
- Care management
- Crisis intervention
- Clinical support
- Risk management
- Service reviews
- Funding panel applications
- Brokering service providers
- Safeguarding
- Financial assessments

- Facilitating hospital discharge
- Delivering and reviewing services
- Provider performance and quality monitoring
- Court of protection applications

Nature of Processing

- Face-to-face
- Emails
- Letters
- Diagnostic tools
- Case recording on MOSAIC and RIO electronic record systems
- Dr / Patient meeting/privilege

Duration of the Processing

The information is held about the service user and other individuals who are associated with the service user for the duration that person is in receipt of a service by the team. Information is then archived for the required period before being destroyed.

SCHEDULE 8:

Integrated Performance Management Framework

1. General

1.1 The Trust (ELFT) and the Council (LBH) are committed to;

- Improving service user and carer experiences with people feeling in control and independent,
- Improving health and care outcomes with enhanced quality and safety,
- Reducing unplanned admissions and attendances in hospital and in admissions to residential care, and

- More effective use of resources & reducing duplication across systems.

1.2 A comprehensive performance framework is in place in both the Trust and the Council which monitors and reports to their respective Performance, Assurance & Governance Boards monthly performance information against National, Commissioning and Foundation Trust targets for health and social care.

1.3 On a monthly basis the Council distribute the Adult Social Care Performance Framework, which includes shared measures from the Adult Social Care Outcomes Framework (ASCOF).

1.4 The Trust will work closely with the Integrated Learning Disability Service (ILDS) and the Council' Performance team to ensure RIO-related datasets are shared and validated, and issues around performance or data quality are identified and remedial action plans are put in place. This includes regular dialogue and joint working between all parties in the best interests for service users and staff.

2. Client & Patient Record Systems

2.1 MOSAIC will be the primary case recording tool for ILDS but RIO will be also be used by clinicians for appointments, clinical encounters etc. Clear guidelines will be issued to reduce the risk of unnecessary duplication and ensure that recording is proportionate.

2.2 Having access to both health and social care information is a priority to ensure a holistic perspective is taken to identifying needs and that levels of risk exposure are identified and managed appropriately.

3 Performance Assessment Framework

3.1 The KPIs which will be routinely reported at Section 75 Partnership Management Meetings will be as follows

- Number of new referrals and outcomes
- Number of transition cases and outcomes
- 28 day assessments
- CPA reviews/Social Care Reviews/ CHC Reviews and outcomes
- Numbers of Carers Assessments and outcomes
- Employment and Accommodation
- Number of funded support packages
- Number of safeguarding concerns received and outcomes
- Number of DOLS
- Service User and Carer Survey ASCOF measures.

4 Performance Effectiveness, Assurance & Service Improvement

4.1 ILDS will be required to deliver specialist health and social care services in the context of enabling and supporting delivery of the Council, Trust and City and Hackney Clinical Commissioning Group's strategic aims, objectives and planning frameworks.

4.2 Performance reporting will be provided by the Council, with the support of the Trust, to the LDPMG meeting. The Council, with the support of the Trust as appropriate will

also provide required reports to the Joint Commissioning and Health & Wellbeing Boards.

4.3 The Council and the Trust will monitor the effectiveness of the partnership arrangements and use measures of performance that will be reviewed annually to assess efficiency and effectiveness. Both parties will continue to work together to improve the quality and responsiveness of services, satisfaction and engagement of staff and financial viability through:

- Provision of Services in a more coordinated way by allowing different professions to work within an integrated case management structure.
- Ensure effectiveness of resources, by reviewing policies and procedures and seeking to deliver efficiencies where possible.
- Explore opportunities to deliver efficiency savings and continue to provide a service in the context of an increasing demand for services.
- Support supplementary commissioning initiatives to provide additional benefit, support and pathway options for Service Users with mental health needs.

5. Complaints

5.1 The Council will provide the first point of contact for a complaints and Members' enquiry procedure that adheres to statutory requirements and covers both health and social care services. The aim will be to provide as seamless an experience for complainants as possible

5.2 If a complainant should complain directly to the Trust about the Service or Staff, this will be referred to the Council in the first instance.

5.3 Where complaints relate to specifically about service provision, Hackney Council will lead on the handling of the complaint, co-coordinating with ELFT where appropriate.

5.4 If a complaint relates solely to ELFT professional practice/regulations, the Head of Service will take advice from ELFT colleagues.

5.4 Both Partners will co-operate with one another in the handling and resolution of any complaint received in relation to the Service and complaints will be investigated in accordance with the Council's complaints procedure

SCHEDULE 9:

Safeguarding

All professionals in ILDS operate within the context of the Pan London Safeguarding procedures. The Pan London multi-agency adult safeguarding policy and procedures are built on strong multi-agency partnerships working together with adults to prevent abuse and neglect where possible, and provide a consistent approach when responding to safeguarding concerns. This entails joint accountability for the management of risk, timely information sharing, co-operation and a collegiate approach that respects boundaries and confidentiality within legal frameworks.

Principles

Professionals are expected to offer advocacy support where appropriate and comply with the six principles of Safeguarding that underpin all adult safeguarding work, namely:

1: Empowerment	Adults are encouraged to make their own decisions and are provided with support and information.	I am consulted about the outcomes I want from the safeguarding process and these directly inform what happens.
2: Prevention	Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination.	I am provided with easily understood information about what abuse is, how to recognise the signs and what I can do to seek help.
3: Proportionate	A proportionate and least intrusive response is made, balanced with the level of risk.	I am confident that the professionals will work in my interest and only get involved as much as needed.
4: Protection	Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding.	I am provided with help and support to report abuse. I am supported to take part in the safeguarding process to the extent to which I want and to which I am able.
5: Partnerships	Local solutions through services working together within their communities.	I am confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature. I am confident that agencies will work together to find the most effective responses for my own situation .
6: Accountable	Accountability and transparency in delivering a safeguarding response.	I am clear about the roles and responsibilities of all those involved in the solution to the problem.

Values:

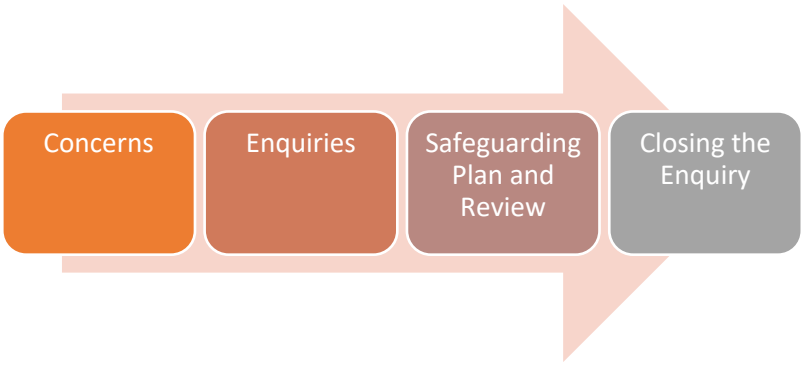
Safeguarding has the highest priority across all organisations. There is a shared value of placing safeguarding within the highest of corporate priorities. Organisations are judged on the effectiveness of safe communities and their values towards safeguarding adults who may be at risk of abuse or neglect. Values include:

- People are able to access support and protection to live independently and have control over their lives.
- Appropriate safeguarding options should be discussed with the adult at risk according to their wishes and preferences. They should take proper account of any

additional factors associated with the individual's disability, age, gender, sexual orientation, 'race', religion, culture or lifestyle.

- The adult at risk should be the primary focus of decision making, determining what safeguards they want in place and provided with options so that they maintain choice and control.
- All action should begin with the assumption that the adult at risk is best-placed to judge their own situation and knows best the outcomes, goals and wellbeing they want to achieve.
- The individual's views, wishes, feelings and beliefs should be paramount and are critical to a personalised way of working with them.
- There is a presumption that adults have mental capacity to make informed decisions about their lives. If someone has been assessed as not having mental capacity, to make decisions about their safety, decision making will be made in their best interests as set out in the Mental Capacity Act 2005 and Mental Capacity Act Code of Practice.
- People will have access to supported decision making.
- Adults at risk should be given information, advice and support in a form that they can understand and be supported to be included in all forums that are making decisions about their lives. The maxim 'no decision about me without me' should govern all decision making.
- All decisions should be made with the adult at risk and promote their wellbeing and be reasonable, justified, proportionate and ethical.
- Timeliness should be determined by the personal circumstances of the adult at risk.
- Every effort should be made to ensure that adults at risk are afforded appropriate protection under the law and have full access to the criminal justice system when a crime has been committed.

Process



Timescales

Stage	Indicative timescales
● **Stage 1: CONCERNS** ● Identify ● Take responsibility ● Respond	● Take immediate action in cases of emergency ● Within 1 working day in other cases
● **Stage 2: ENQUIRIES** ● Initial conversation ● Planning meetings ● Enquiry actions ● Agreeing outcomes	● Same day concern received if not already taken place ● Within 5 working days Target time within 20 working days ● Within 5 working days of enquiry report.
● **Stage 3: SAFEGUARDING PLAN & REVIEW** ● Safeguarding Plan ● Review	● Within 5 working days of enquiry report ● Not more than 3 months, but dependent upon risk
● **Stage 4: CLOSING THE ENQUIRY** ● Closing the enquiry	● Actions immediately following decision to close where possible. ● Other actions within 5 working days

For further reference visit: www.londonadass.org.uk '*LONDON MULTI-AGENCY ADULT SAFEGUARDING POLICY & PROCEDURES*' – updated August 2016.

SCHEDULE 10:

Partnership Governance Arrangements

1 Learning Disability Partnership Management Group

1.1 This Agreement will be managed by the Learning Disability Partnership Management Group, hereafter referred to as "LDPMG".

1.2 LDPMG Membership shall include the following ('LDPMG Members'):

The Trust

- Borough Director, City and Hackney or their nominee
- ELFT Learning Disability Lead or their nominee
- ELFT Finance Lead or their nominee

The Council

- Director of Adult Services or their nominee
- Assistant Director of Finance (Health & Community Services or their nominee)
- Head of Hackney Integrated Learning Disability Service or their nominee.
- The LDPMG will be supported by other senior managers and officers from the Council, the Trust or external bodies from time to time, as required.

1.3 **Chair**

1.3.1 The LDPMG chair and co-chair will be the Director of Adult Services (London Borough of Hackney) and the Borough Director (City and Hackney).

1.3.2 If the Chair is absent from any meeting, the Vice Chair shall chair the meeting. In the absence of both Chair and Vice Chair the Officers of the LDPMG present shall choose one of their number to be Chair of the meeting before any other business is transacted.

1.4 **Values**

- **Accountability** – activities must be able to stand the test of scrutiny, public judgments of propriety and professional codes of conduct
- **Probity** - there should be an absolute standard of honesty: integrity should be the hallmark of all personal conduct in decisions affecting service users, staff, suppliers etc. and in the use of information acquired in the course of discharging duties.
- **Openness** - there should be sufficient transparency about activities to promote confidence between partners, staff, service users, carers and other stakeholders.

1.5 **Role of LDPMG**

The LDPMG shall:

- Receive the necessary information as set out in this Schedule;
- Review jointly the operation of this Agreement and consider its renewal;

- Agree such variations to this Agreement from time to time as it thinks fit;
- Review and confirm annually the revised annual finance arrangements in accordance with Schedule 5.
- Consider progress on the Aims and Objectives at Schedule 1 and consult further where necessary; and
- Provide an annual report on the Agreement and approve the reports prepared in accordance with Clause 12 of the Agreement.
- Confirm the Annual Service Improvement Plan as defined within the agreement.
- Ensure there is a suitable framework and mechanisms in place in order to assure appropriate clinical governance. This will include the provision of assurance to the LDPMG that services are providing safe and effective care and to external inspectors such as NHSLA, OFSTED and the Care Quality Commission.

1.6 **Meetings**

- The LDPMG shall meet at least four times a year.
- The quorum for meetings of the LDPMG shall be a minimum of three LDPMG Members, (two representatives of the Council and one representative of the Trust).
- Decisions of the LDPMG shall be made unanimously by those present.
- Minutes of all decisions shall be kept and copied to the authorised officers of the Partners within seven (7) days of every meeting

1.7 **Delegated authority**

1.7.1 The LDPMG is authorised within the limits of delegated authority of the LDPMG Members (which is received through their respective organisation's own scheme of delegation) to:

1.7.2 Confirm pursuant to Clause 8 of the Agreement, the respective services, budgets, staff and premises within the scope of this agreement.

- The LDPMG shall not govern any Staff or Managed staff that are not listed at Schedule 4 or any amendment to it, who shall remain accountable to and the responsibility of their respective current employer.
- Staff listed at Schedule 4 shall be managed in accordance with arrangements set out at Schedule 4 and the appended Management Agreement

1.8 **Information and Reports**

The Director of Adult Services and the Borough Director, City and Hackney shall supply to the LDPMG the financial and activity information as required.

1.9 **Post-termination**

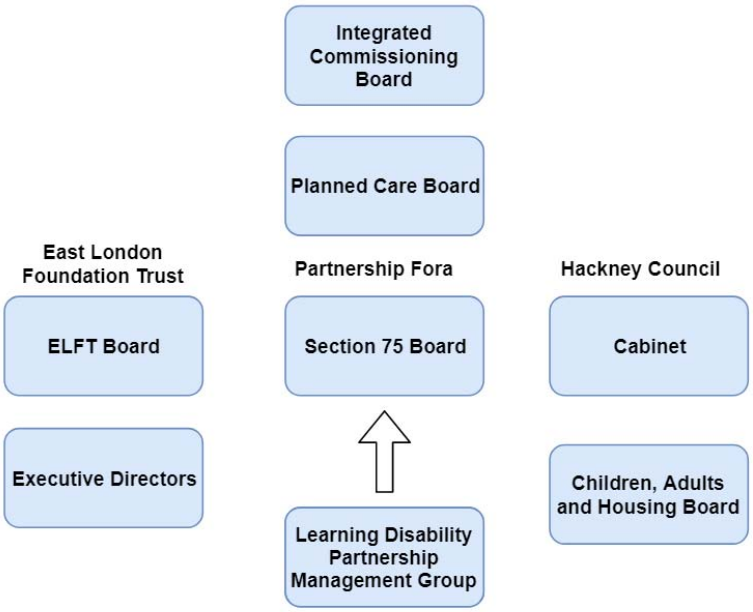
1.9.1 The LDPMG shall continue to operate in accordance with this Schedule following any termination of this Agreement under Clause 16 of the Agreement, for as long as is necessary.

1.10 **Management of over and underspends**

1.10.1 ELFT bill on actuals to a maximum of the agreed budget. Any planned overspend will be flagged to the Partnership Board and they will agree how the financial risk of any potential overspend will be managed.

1.10. 2 Only by agreement of the partnership management group will funding either come from the pooled commissioning budget or be escalated to the commissioner for additional funding. Any overspend not agreed with the Partnership Board will be at risk to the providers ELFT and LBH.

1.10. 3 Where overspend is required to maintain budgeted staffing levels but is not approved, ELFT and LBH will work together though the partnership board to agree temporary amendments to delivery.



2. The Council is responsible but both partners are accountable for service quality and governance.

2.1 Both partners agree to establish mechanisms to provide detailed scrutiny and enable the service to discharge its responsibilities appropriately. These include the robust management of financial risk and probity, and the oversight of clinical and other practice standards and delivery.

3 Inspection and Reviews

3.1 The Partners will have reasonable access to each other's records, performance information, etc. to assist with any required inspections, investigations or reviews of services.

4 Complaints Management

4.1 In accordance with clause 30 of this Agreement, the Council will provide the first point of contact for a complaints and Members' enquiry procedure that adheres to statutory requirements and covers both health and social care services. The aim will be to provide as seamless an experience for complainants as possible

4.2 If a complainant should complain directly to the Trust about the Service or Staff, this will be referred to the Council in the first instance.

4.3 Both Partners will co-operate with one another in the handling and resolution of any complaint received in relation to the Service and complaints will be investigated in accordance with the Council's complaints procedure.

5 Clinical Practice Policies

5.1 The Trust will have in place a set of policies that will provide an appropriate framework for practice/service delivery within the Integrated Service. Where possible, all relevant clinical/practice policies from the Partners will be harmonised.

6 Assessing performance against section 75 agreement

6.1 The Partners will agree indicators from time to time that will enable the assessment of performance against this Agreement, which will be included in Schedule 8 (Integrated Performance Management Framework).

6.2 A report shall be prepared by the Director of Adult Services for each LDPMG meeting, on any major decisions to be taken by the LDPMG.

7 Financial, staffing and activity reporting

7.1 The LDPMG shall receive quarterly financial reports in line with Schedule 8 and Clause 9 Agreement.

7.2 Financial reports will provide (i) a breakdown of annual budgeted staffing, other costs and income, (ii) comparable amounts of expenditure and income incurred to date, (iii) comparable projected annual expenditure and income, (iv) projected annual spend variations in respect of staffing, other costs and income, and (iv) explanations of such variations which exceed 5% of budget and £10k.

7.3 Quarterly staffing reports will show which posts are filled permanently, which are filled by agency staff, and which are vacant. Actions to recruit permanent staff and fill vacancies will be reported. Quarterly sickness absences will also be reported.

7.4 Performance and activity reporting to the PMG will take place on a quarterly basis as detailed within Schedule 8.

7.5 Where appropriate e.g. to address major risks, actual overspend issues or areas of concern the LDPMG will request quarterly and detailed progress reporting on particular areas of finance and/or performance from lead manager(s) and until such time as appropriate remedial action has been taken.

8 Rules of conduct and agreement of the LDPMG

8.1. No Officer of the LDPMG shall acquire any interest in property belonging to the Council or the Trust or receive remuneration or be interested (otherwise than as an Officer of the LDPMG) in any contract entered into by the LDPMG.

8.2. Officers of the LDPMG shall comply with both the Local Council's Codes and Protocol for Members and Officers and the National Health Service Guidance on Business Ethics and code of conduct for NHS Managers to the extent that the same may properly be applied to the circumstances of this Executive Group.

8.3 LDPMG members must declare interests that are relevant and material to the Executive Group.

8.4 If LDPMG members have any doubt about the relevance of an interest, this should be discussed with the Chair of the LDPMG. Any declaration or discussion of the Chair's interests should be made to the Vice-Chair.

8.5 LDPMG members shall declare in advance of an Executive Group meeting any conflict of interest in relation to the agenda for that meeting. When such a conflict of interest is declared the relevant Executive Group Officer shall appoint an alternate for that meeting in accordance with paragraph 5.4 of this Constitution.

8.6 Any decision of the LDPMG shall take effect as either a) a joint decision on the basis of a collective agreement or vote or b) a decision of the relevant Officer subject to the respective powers delegated to them by their employing Partner.

8.7 When an Officer of the LDPMG does not have the delegated power to make a decision and this is required the meeting shall either be adjourned or the decision referred back to the relevant Partner.

9. Operational management and accountability for delivering ILDS services will be jointly agreed by the parties to this agreement. Day-to-day responsibility for the budget across the service will be with the Head of Service post-holder. The Staff identified within the service structure have clear, delegated powers of leadership and accountability. Strategic accountability will be exercised by London Borough of Hackney, East London Foundation Trust and the City and Hackney Clinical Commissioning Group via the Section 75 Agreement and the CCG's Planned Care Board.

10. LDPMG members will review the section 75 provider agreement schedules annually to ensure they remain fit for purpose and adequate to support the evolving needs of the service.

11. Any proposed changes to the ILDS establishment must be presented and formally approved by LDMPG before they can be made.

APPENDIX 1

RELATES TO SCHEDULE 4: HUMAN RESOURCE MANAGEMENT AND GOVERNANCE

MANAGEMENT AGREEMENT

THIS MANAGEMENT AGREEMENT is made on **1st April 2019** between: -

(1) **London Borough of Hackney** of Town Hall, Mare Street, London E8 1EA ("the Host Council)

(2) **East London Foundation Trust** of Trust Headquarters, Robert Dolan House, 9 Alie Street, London, E1 8DE ("The Employer")

1. INTRODUCTION

1.1 This Management Agreement is entered as a consequence of an Agreement between the London Borough of Hackney and the East London NHS Foundation Trust dated 1st April 2019 under section 75 of the National Health Service Act 2006 ("the s75 Agreement") for the integration of learning disability services incorporating clinical services provided by the East London Foundation Trust and social care services provided by the London Borough of Hackney.

2 MANAGEMENT

2.1 With effect from 1st April 2019 the London Borough of Hackney will manage East London NHS Foundation Trust Staff (referred to from here on as Managed staff) on the terms of this Management Agreement. Subject to earlier termination as provided for in this Management Agreement, the management of the Managed Staff will continue and is reviewable annually during the period of the s75 Agreement provided that such Managed Staff remain seconded by the Employer.

2.2 This management agreement applies to former Managed Staff who are no longer employed by the East London Foundation Trust and the Council where appropriate e.g. where liabilities from prior employment require continued management.

2.3 The Managed Staff shall be located at their current working base where he/she shall act and perform the duties as set out in the Managed Staff 's contract of employment with the Employer. However, it is recognised that in order to meet changes in service provision this location and aspects of the role may need to change over time by the partnership. The Managed Staff will be consulted in relation to any proposed changes to either location or role as may be reasonably required by the Council, as service host in conjunction with the Employer if necessary.

3 CONDITIONS

3.1 The Managed Staff Terms and Conditions of Employment with the Employer shall remain in force during the period of this Management Agreement.

3.2 The Managed Staff 's existing Job Description applies at present. Any changes will be subject to consultation with the Employer, Managed Staff and Trade Unions.

3.3 The Managed Staff shall remain employees of the Employer at all times and shall not be deemed to be employees of the Council by virtue of this Management Agreement and shall not be entitled to any salary, pension, bonus or other fringe benefits from the Council.

3.5 The Managed Staff's continuity of service with the Employer will be preserved for both statutory and contractual purposes during the period of management.

3.6 The Managed Staff will be subject to the Employer's Human Resources Policies and Procedures including and not limited to continuity of service, sickness absence, performance management and annual leave.

4 LIABLITY AND INDEMNITIES

4.1 The Employer shall indemnify and keep indemnified, the Council in relation to any claims, charges or liabilities for (including but not limited to) any income tax, national insurance, pension contributions, or other statutory charges or remuneration or other compensation arising from or in relation to the services provided by the Managed Staff under this Agreement or the Managed Staff alleging or being found to be an employee of the Council or otherwise. The Council agrees to notify the Employer of any such claims charges or liabilities received by the Council.

4.2 The Council shall not be liable for any act or omission on the part of the Managed Staff during the term of this Management Agreement including, without limitation, for any claim by any third party arising out of or in respect of any act or omission of any Managed Staff and shall incur no liability for loss, damage or injury of whatever nature sustained by the Managed Staff.

4.3 The Employer hereby indemnifies the Council against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages and demands arising out of or resulting from breach of this Management Agreement or the management arrangements set out in Schedule 4 of the s75 Agreement or any act or omission or default of the Managed Staff including without limitation:

4.3.1 Any loss of or any damage to any property;

4.3.2 All financial loss;

4.3.3 Those resulting from any breach by the Managed Staff of any intellectual property rights owned by the Employer, the Council or a third party;

4.3.4 Injury to or death of any person caused by any negligent act or omission or wilful misconduct of the Managed Staff, whether resulting in material or financial loss or damages or death or injury to persons or any other loss or damage whatsoever;

4.3.5 Any and all liability arising from any breach of the provisions of the Data Protection Act 2018 or General Data Protection Regulations 2018 by the Managed Staff.

4.4 The Employer hereby indemnifies the Council against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages, demands, penalties, fines or expenses suffered or incurred by the Council which are attributable to any act or omission by the Employer or any other person for whom the Employer is liable arising out of:

4.4.1 The employment or termination of employment of the Managed Staff during the term of this Management Agreement;

4.4.2 The engagement or termination of engagement of the Managed Staff under the terms of this Management Agreement during the term of this Management Agreement;

4.4.3 Any breach by the Employer of any collective agreement with a trade union, staff association or employee representatives in respect of the Managed Staff;

4.4.4 Any claim by a member of the Managed Staff for personal injury, accident or illness suffered or incurred during the term of this Management Agreement; and / or

4.4.5 Any claim by a member of the Managed Staff for breach of contract or in tort, unfair dismissal, redundancy, statutory redundancy, equal pay, discrimination of any kind or under any legislation applicable in the United Kingdom.

4.5 The Council shall indemnify the Employer against any and all claims, liabilities, actions, proceedings, costs (including legal fees), losses, damages, demands, penalties, fines or expenses suffered or incurred by the Employer which are attributable to any act or omission by the Council or any other person for whom the Council are liable arising out of:-

4.5.1 Any breach by the Council of any collective agreement with a trade union, staff association or employee representatives in respect of the Managed Staff (Council Managers will be provided with advice and support to enable them to understand and adhere to any and all collective agreements affecting the employment of the Managed Staff);

4.5.2 Any breach by the Council of any of the Employer's disciplinary, grievance or other employee related rules and procedures that shall apply to the Managed Staff during the term of this Management Agreement;

4.5.3 Any claim for by a member of the Managed Staff for personal injury, accident or illness suffered or incurred during the term of this Management Agreement due to any negligent act or omission or misconduct of the Council or its staff;

4.5.4 Any claim by a member of the Managed Staff for breach of contract, unfair dismissal, equal pay, discrimination of any kind or under any legislation applicable in the United Kingdom where such claim arises directly as a result of any negligent act or omission or misconduct of the Council or its staff.

5 CONDUCT OF CLAIMS

5.1 If the Council becomes aware of any matter that may give rise to a claim against the Managed Staff and/or the Employer, notice of that fact shall be given as soon as possible to the Employer.

5.2 Without prejudice to the validity of the claim or alleged claim in question, the Council shall allow the Employer and its professional advisors to investigate the matter or circumstance alleged to give rise to such claim and whether and to what extent any amount is payable in respect of such claim, and for such purpose, the Council shall give subject to being paid all reasonable costs and expenses, all such information and assistance, including access to premises and personnel, and the right to examine and copy or photograph any assets, accounts, documents and records, as

the Employer or its professional advisors may reasonably request provided that nothing in this clause shall be construed as requiring the Council to disclose any document or thing which is subject of any privilege and that, if any Confidential Information (as defined in clause 15 below) is disclosed, the Employer shall provide the Council with written assurances in relation to its compliance with clause 15. The Employer agrees to keep all such information confidential and only to use it for such purpose.

5.3 In relation to claims to which the Employer is providing an indemnity to the Council, the Council will make no admission of liability by or on behalf of the Council and any such claim shall not be compromised, disposed of or settled without the consent of the Employer.

5.4 Subject to clause 5.5, The Employer will be responsible for managing all claims and take such action to avoid, dispute, deny, defend, resist, appeal, compromise or contest any such claim or liability (including, without limitation, making counterclaims or other claims against third parties) in the name of and on behalf of the Council and to have the conduct of any related proceedings, negotiations or appeals.

4.5 Notwithstanding clause 5.4, The Employer must first consult with the Council before any action is taken in its name and both parties must mutually consent to any proposed action taken by the Employer (such consent not to be unreasonably withheld), subject to clause 5.6

4.6 Notwithstanding clause 5.4 – 5.5, the Insurers reserve the right in its absolute discretion to take full control of claims it deems to fall within its authority.

6 LEAVE

6.1 The Council will inform the Employer's HR team of any Managed Staff member's absence, including but not limited to sickness absence, industrial injury or other disability as soon as is reasonably practicable. It is the Managed Staff 's responsibility to follow the Employer's sickness absence reporting procedures at all times.

6.2 The Managed Staff shall be entitled to holiday during the period of this Management Agreement in accordance with the Managed Staff's terms and conditions of employment with the Employer. Managed Staff are required to request authority for leave from their line manager and follow the Employer's recording procedures.

7 HEALTH AND SAFETY

7.1 The Council shall ensure that the Managed Staff observe its health and safety policies and procedures and maintains a safe method of working. This will include ensuring that there is in place an effective Lone Working Policy for all staff in the service.

7.2 The Employer shall ensure that the Managed Staff comply with Section 7 of the Health and Safety at Work Act 1974 and in particular that they take reasonable care for their own health and safety and that of others who may be affected by their acts or omissions at work and to observe all reasonable safety instructions given to them by the Council.

8 CONFLICTS OF INTEREST

8.1 The Council will ensure that Managed Staff are aware that they must declare and seek agreement from the Employer regarding any interests, financial or otherwise, which may give rise to a conflict of interest during the course of this Management Agreement in line with the Employer's Code of Conduct. Such interests include other employment, business interests and positions of authority in a charity or voluntary body in the field of health and social care and in connection with a voluntary or other body contracting for NHS services.

9. PAYMENT OF SALARIES AND EXPENSES

9.1 The Managed Staff will continue to be paid by the Employer in accordance with the Managed Staff terms and conditions of employment whilst seconded to the Council.

9.2 It is agreed that the Employer shall be solely responsible for all income tax liability, national insurance contributions, pension contributions or other statutory charges in respect of any payment to the Managed Staff for the provision of services by the Managed Staff to the Council under this Management Agreement.

9.3 Any salary increments applicable to the Managed Staff 's substantive post with the Employer will continue to apply subject to the Employer's current Pay Review.

10 HUMAN RESOURCES SERVICES

10.1 Replacement of Managed Staff

The administrative services to support the recruitment and selection of Managed Staff will continue to be undertaken by the Employer, supported by the Council as appropriate.

10.2 Employee Relations

10.2.1 The Employer will provide advice to the Managed Staff on the Employer's policies including but not limited to disciplinary (including conduct), grievance, ill health, maternity leave and general terms and conditions of service. The Employer's Human Resources Policies are available from the Employer's Human Resources Department.

10.2.2 The Employer will be responsible for ensuring the Managed Staff are kept updated with all changes in the Employer's policies and procedures, although this may be communicated to the Managed Staff through Council staff.

10.3 Policies and Procedure

10.3.1 During the term of this Management Agreement, the Council in consultation with the Employer's Human Resources Department shall implement the Employer's policies and procedures in respect of the Managed Staff, so far as they comply with current employment legislation, with the exception of line management supervision as Managed Staff will use the Council's day to day policies in respect of these matters. The Council shall notify the Employer if it becomes aware of any act or omission by any member of the Managed Staff which may constitute a material breach of their employment contract.

10.3.2 The Employer authorises the Council to take action in respect of the Managed Staff pursuant to the Employer's Conduct Policy save for any action, which could result in

the dismissal of Managed Staff . In such circumstances the Employer shall take appropriate steps in accordance with its Conduct Policy and Procedure.

10.3.3 The Council may, should it consider necessary to do so, suspend Managed Staff from duty in accordance with the Employer's Conduct Policy and in consultation with the Employer's Human Resources Department provided that such a suspension shall be notified to the Employer no later than the following working day.

10.3.4 The Employer authorises the Council to deal with any grievances raised by the Managed Staff against the Council in accordance with the Employer's grievance policy. The Council will notify the Employer of any grievances received by the Council including those against the Employer within 1 working day or as soon as reasonably possible.

10.3.5 For the avoidance of doubt, nothing in clause 10 or in this Management Agreement generally shall be construed or have effect as construing any relationship of "employer" or "employee" between the Council and the Managed Staff.

10.4 Workforce Information

10.4.1 Workforce information regarding Managed Staff will continue to be collected and retained by the Employer. However, it is recognised that the Council will require data concerning Managed Staff in order to support the planning and delivery of services. The Employer in accordance with the format and deadlines identified by the Council will provide this information as required.

11 MANAGEMENT

11.1 The Managed Staff shall be line managed on a daily basis by and directly accountable to a designated line manager in the Council's organisational structure during the term of this Management Agreement; the Employer will provide access to ongoing professional clinical supervision by a suitably qualified professional.

12 PROFESSIONAL DEVELOPMENT

12.1 The Employer will work with the Council to ensure the Managed Staff's professional and developmental needs are identified and met. Performance Development Reviews, Performance Management processes, and training of the Managed Staff will be undertaken by the Council or the Trust as appropriate and in accordance with clause 12.2 below where necessary.

12.2 The Employer and the Council acknowledge and agree that all training specific to or relating to the services that is provided in-house by both partners shall be made available to the staff of the other Partner to attend. In the event that a Partner purchases external training through a third party provider or otherwise that is specific to or relating to the services, this training shall also be made available to the staff of the other partner to attend but where any such staff attend the training, the other partner shall be required to contribute to the cost of the training proportionate to the number of its staff who confirm their intention to attend through their employer and actually attend the training.

13 MANAGEMENT OF CHANGE

13.1 It is recognised that the Council and the Employer in delivering and developing Learning Disability Services will face organisational restructuring and changes in employment levels. In the event that the Managed Staff are affected by organisational change, the Council and the Employer will ensure that changes happen following full consultation with his/her union representative and that changes comply with the Employer's employment policies.

14 DATA PROTECTION

14.1 The Employer consents to the Council holding, disclosing, using or otherwise processing any information about the Managed Staff which they provide to the Council on which the Council may acquire as a result of this Management Agreement.

14.2 The Employer and the Council agree to protect any personal data held in relation to the Managed Staff in accordance with the Data Protection Act 2018 and General Data Protection Regulations 2018.

15 CONFIDENTIALITY

15.1 It is acknowledged that to enable the Managed Staff to provide the Services, the Council will provide the Managed Staff with information of a highly confidential nature which is or may be private, confidential or secret, being information or material which is the property of the Council or which the Council is obliged to hold confidential including, without limitation, all official secrets, information relating to the working of any project carried on or used by the Council, research projects, strategy documents, tenders, financial information, reports, ideas and know-how, employee confidential information and patient confidential information and any proprietary Council information (any and all of the foregoing being "**Confidential Information**").

15.2 The Council shall ensure that the Managed Staff adopt all such procedures as the Council may reasonably require and to keep confidential all Confidential Information and that the Managed Staff shall not (save as required by law) disclose the Confidential Information in whole or in part to anyone and not disclose the Confidential Information other than in connection with the provision of the services provided pursuant to the s75 Agreement.

15.3 The Employer and the Council agree that they will keep any Confidential Information relating to the other party that they obtain as a result of this Management Agreement secret and shall not use or disclose any such Confidential Information.

15.4 The obligations under this Management Agreement apply to all and any Confidential Information whether the Confidential Information was in or comes into the possession of the relevant person prior to or following this Management Agreement and such obligations shall continue for the duration of this Management Agreement in accordance with clause 2.1 and at all times following the termination of this Management Agreement but shall cease to apply to information which may come into the public domain otherwise than through unauthorised disclosure by the Managed Staff .

15.5 Nothing in this Management Agreement shall prevent the Managed Staff from disclosing information that a member of the Managed Staff is entitled to disclose under the Public Interest Disclosure Act 1998, provided that the disclosure is made in accordance with the provision of that Act.

15.6 The Council shall ensure that the Employee shall at any time during the duration of this Management Agreement if so required by the Council surrender to the Council all original and copy documents in the possession, custody or control (including, without limitation, all books, documents, papers, materials) of the Managed Staff belonging to the Council or relating to the business of the Council together with any other property belonging to the Council.

16 TERMINATION

16.1 In the event of termination of the s75 Agreement howsoever arising, this Management Agreement will automatically terminate.

17 REVIEW AND VARIATION

17.1 This Management Agreement will remain the subject of periodic review and amendment as necessary in light of changing service needs and legislative developments.

17.2 The parties agree that any amendments or variations to this Agreement must be in writing and signed by authorised representatives of the parties.

18 GENERAL

18.1 If any provision or term of this Management Agreement shall become or be declared illegal invalid or unenforceable for any reason whatsoever, including without limitation, by reason of provisions of any legislation or by reason of any decision of any court or other body having jurisdiction over the parties, such terms or provisions shall be divisible from this Management Agreement and shall be deemed to be deleted in the jurisdiction in question provided always that if any such deletion substantially affects or alters the commercial basis of this Management Agreement, the parties shall negotiate in good faith to amend and modify the provisions or terms of this Management Agreement as may be necessary or desirable in the circumstances.

18.2 This Management Agreement does not create any partnership or agency relationship between the Employer and the Council.

18.3 This Management Agreement shall be in substitution for any previous letters of appointment, agreements or arrangements, whether written, oral or implied, relating to the management of the Managed Staff.

18.4 This Management Agreement shall be governed by and construed in accordance with English law. The Employer and the Council agree that any dispute arising under this Management Agreement or in connection with it shall be decided in the English Courts, which shall have the sole jurisdiction in any such matter.

Signed for the Trust ….....

Name ….....

Post title ….....

Date _____

Signed for the Council ….....

Name ….....

Post title ….....

Date _____

APPENDIX 2

RELATES TO SCHEDULE 5: FINANCE AND RESOURCES

East London Foundation Trust funded posts – Banding MID Points based on 2018/19 pay award (latest available)

2019-20 BUDGETS				
ILDS STAFFING BUDGET			**2019-20 ANNUAL PRO-RATA COST**	
Position Title	**Grade**		**Funded WTE**	**Mid-Point**
Consultant Psychiatrist	**Consultant (post 31 Oct)**		1.00	153,589
ST4-6 (fully funded by ELFT)	Specialty Registrar ST4/SpR4		1.00	83,490
CT1-3	Specialty Registrar CT 2		1.00	63,140
Medical Staff Total			**3.00**	**300,219**
Consultant Clinical Psychologist Band 8B	Review Body Band 8 - Range B		1.00	82,094
Highly Specialist Clinical Psychologist Band 8a	Review Body Band 8 - Range A		1.00	69,502
Clinical Psychologist Band 7	Review Body Band 7		1.00	58,950
Assistant Psychologist Band 5	Review Body Band 5		1.00	40,804
Behaviour Analyst Band 7 (PAMS B7)	Review Body Band 7		1.00	58,950
PSYCHOLOGY TOTAL			**5.00**	**310,300**
AOT Band 7	Review Body Band 7		1.00	58,950
Highly Specialist Occupational Therapist Band 7	Review Body Band 7		1.00	58,950
Specialist Occupational Therapist Band 6	Review Body Band 6		1.00	50,536
Occupational Therapist Band 5 - VACANT	Review Body Band 5		1.00	40,804
OCCUPATIONAL THERAPY TOTAL			**4.00**	**209,240**
Highly Specialist S&LT Band 7	Review Body Band 7		1.00	58,950
Specialist S& LT Band 6	Review Body Band 6		1.00	50,536
SPEECH & LAUNGUAGE TOTAL			**2.00**	**109,486**
Highly Specialist Physiotherapist Band 7	Review Body Band 7		1.00	58,950
Physiotherapist Band 5 - VACANT	Review Body Band 5		1.00	40,804
PHYSIOTHERAPY TOTAL			**2.00**	**99,754**
Learning Disabilities Nurse Band 7	Review Body Band 7		2.00	117,900
Community Psychiatric Nurse Band 7	Review Body Band 7		0.40	23,580
Learning Disabilities Nurse Band 6	Review Body Band 6		2.80	141,501
Nurse Band 5	Review Body Band 5		1.00	40,804
NURSING TOTAL			**6.20**	**323,785**
Dietician Band 6	Review Body Band 6		0.40	20,214
Health Care Support Worker Band 4	Review Body Band 4		2.00	66,908
Medical Co-ordinator Band 4	Non Review Body Band 4		0.20	6,691

Admin & Clerical Band 4 - VACANT	Non Review Body Band 4		0.80	26,763
Admin & Clerical Band 3	Non Review Body Band 3		1.00	30,043
Specialist Health Team Manager Band 8a	Review Body Band 8 - Range A		1.00	69,502
OTHER HEALTH AND CLINICAL STAFF			**5.40**	**220,121**
ILDS STAFFING BUDGET (excluding Management Overheads - 2019-20 TOTAL			**27.60**	**1,572,905**
8% Management Overheads				119,153
ILDS STAFFING BUDGET (including Management Overheads - 2019-20 TOTAL			**27.60**	**1,692,058**

East London Foundation Trust funded posts – Banding TOP Points based on 2018/19 pay award (latest available)

2019-20 BUDGETS				
ILDS STAFFING BUDGET			**2019-20 ANNUAL PRO-RATA COST**	
Position Title	**Grade**		**Funded WTE**	**Top**
Consultant Psychiatrist	**Consultant (post 31 Oct)**		1.00	171,003
ST4-6 (Fully funded by ELFT)	Specialty Registrar ST4/SpR4		1.00	83,490
CT1-3	Specialty Registrar CT 2		1.00	63,140
Medical Staff Total			**3.00**	**317,633**
Consultant Clinical Psychologist Band 8B	Review Body Band 8 - Range B		1.00	85,728
Highly Specialist Clinical Psychologist Band 8a	Review Body Band 8 - Range A		1.00	72,700
Clinical Psychologist Band 7	Review Body Band 7		1.00	63,667
Assistant Psychologist Band 5	Review Body Band 5		1.00	45,190
Behaviour Analyst Band 7 (PAMS B7)	Review Body Band 7		1.00	63,667
PSYCHOLOGY TOTAL			**5.00**	**330,952**
AOT Band 7	Review Body Band 7		1.00	63,667
Highly Specialist Occupational Therapist Band 7	Review Body Band 7		1.00	63,667
Specialist Occupational Therapist Band 6	Review Body Band 6		1.00	55,329
Occupational Therapist Band 5 - VACANT	Review Body Band 5		1.00	45,190
OCCUPATIONALTHERAPY TOTAL			**4.00**	**227,853**
Highly Specialist S&LT Band 7	Review Body Band 7		1.00	63,667
Specialist S& LT Band 6	Review Body Band 6		1.00	55,329
SALT TOTAL			**2.00**	**118,996**
Highly Specialist Physiotherapist Band 7	Review Body Band 7		1.00	63,667

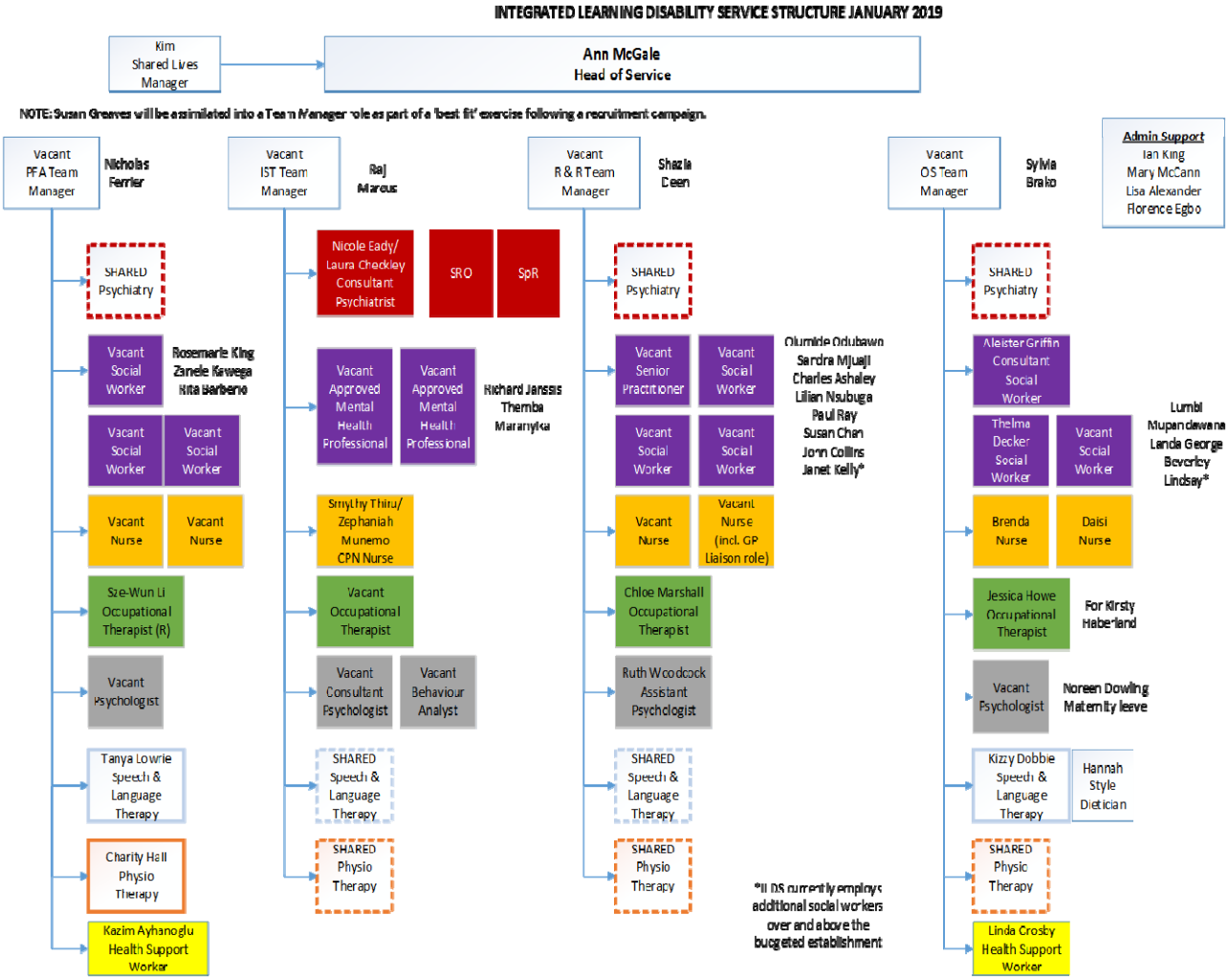
Physiotherapist Band 5 - VACANT	Review Body Band 5		1.00	45,190
PHYSIOTHERAPY TOTAL			**2.00**	108,857
Learning Disabilities Nurse Band 7	Review Body Band 7		2.00	127,334
Community Psychiatric Nurse Band 7	Review Body Band 7		0.40	25,467
Learning Disabilities Nurse Band 6	Review Body Band 6		2.80	154,921
Nurse Band 5	Review Body Band 5		1.00	45,190
NURSING TOTAL			**6.20**	**352,912**
Dietician Band 6	Review Body Band 6		0.40	22,132
Health Care Support Worker Band 4	Review Body Band 4		2.00	70,844
Medical Co-ordinator Band 4	Non Review Body Band 4		0.20	7,084
Admin & Clerical Band 4 - VACANT	Non Review Body Band 4		0.80	28,338
Admin & Clerical Band 3	Non Review Body Band 3		1.00	31,168
Specialist Health Team Manager Band 8a	Review Body Band 8 - Range A		1.00	72,700
OTHER HEALTH AND CLINICAL STAFF			**5.40**	**232,266**
ILDS STAFFING BUDGET (excluding Management Overheads - 2019-20 TOTAL			**27.60**	**1,689,469**
8% Management Overheads				128,478
ILDS STAFFING BUDGET (including Management Overheads - 2019-20 TOTAL			**27.60**	**1,817,947**

London Borough of Hackney funded posts – TOP of spinal points based on 2019/20 pay award (latest available)

Current post-holder	Post number	Post title	Salary grade	Spinal point	FTE	Total annual budget £
	22504	Head of Integrated Learning Disability Service	SM14/B9	68	1.00	£109,233
	23072	Team Manager Referral & Review Team	P06/8A	44	1.00	£62,507
	New	Team Manager Intensive Support Team	PO6/8A	44	1:00	£62,507
	New	Team Manager Preparing for Adulthood (PFA) Team	PO6/8A	44	1:00	£62,507
	10938	Approved Mental Health Practitioner Intensive Support Team	P04	39	1.00	£56,256
	New	Approved Mental Health Practitioner Intensive Support Team	PO4	39	1:00	£56,256
	New	Senior Practitioner Referral & Review Team	PO4	39	1:00	£55,256
	23178	Social Worker Referral & Review Team	P03	36	1.00	£52,495
	10945	Social Worker Referral & Review Team	P03	36	1.00	£52,495
	10946	Social Worker	P03	36	1.00	£52,495

		Referral & Review Team				
	New	Consultant Social Worker Ongoing Support Team	PO5	42	1:00	£60,010
	23176	Social Worker Ongoing Support Team	P03	36	1.00	£52,495
	23177	Social Worker Ongoing Support Team	P03	36	1.00	£52,495
	10947	Social Worker PFA Team	P03	36	1.00	£52,495
	New	Social Worker PFA Team	P03	36	1.00	£52,495
	New	Social Worker PFA Team	P03	36	1.00	£52,495
Total ILDS - LBH Staff Budget 2019/20					**16:00**	**£945,492**

APPENDIX 3



APPENDIX 4

HEAD OF LEARNING DISABILITY JOB DESCRIPTION

LONDON BOROUGH OF HACKNEY

Job Description

POST TITLE:	Head of Learning Disability Service
DIRECTORATE:	Children's, Adults and Community Health
SERVICE:	Integrated Learning Disability and Direct Payments
GRADE:	SM1 (or Band 8d equivalent for AfC)
LOCATION:	London Borough of Hackney
RESPONSIBLE TO:	Director – Adult Social Care and Commissioning
RESPONSIBLE FOR:	Integrated Learning Disability and direct payments services across Health and Adult Social Care

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PURPOSE OF THE JOB:

- The postholder is responsible and accountable for
- The provision of the integrated service to people with Learning Disability living in Hackney. This is provided under an integrated arrangement with the East London Foundation Trust.
- The delivery of the direct payments service
- To lead the development and strategic direction of the new service structures
- To devise operational guidelines to underpin a fully integrated service to people with learning disability.
- To be the lead officer for Learning Disability on Health and Social Care strategic partnership Boards.
- To lead on the coordination of services for people with learning disability across London Borough of Hackney, health agencies including GP practices, the Voluntary Sector and

specific cultural and community groups such as the Orthodox Jewish and Turkish communities.

- To ensure that all services meet the requirements of the Mental Health Act, Community Care Act and related legislation, Department of Health policy directives, Social Services Inspectorate standards, City of London and London Borough of Hackney objectives.

KEY RESPONSIBILITIES

Strategic Thinking and Planning

- To lead and advise on strategies for service development and improvements, and the achievements of City of London and London Borough of Hackney Borough departmental and customer objectives

- To be responsible for effective joint performance management arrangements are in place to achieve strategies, objectives and business plans, translating strategic aims into practical and achievable plans.

- To be responsible for ensuring that joint performance review mechanisms are in place to monitor extent of progress and achievement of objectives and goals.

- As a senior manager to actively contribute to the corporate management of the Council by participating in Council-wide developments and initiatives in pursuit of Council aims and objectives

Managing Services and Delivery

- To ensure that services meet the relevant legislative requirements arising from e.g the Care Act 2014 and the SEND reforms included in the Children and Families Act 2014.

- To lead the implementation and effective management of a preparing for Adulthood service, in partnership with Children and Families and Hackney Learning Trust**.**

- To be responsible for ensuring that all work activity is underpinned by effective work processes to deliver service outcomes on time, in budget and to agreed quality standards.

- To manage a service which is driven by the principles of choice, control and independence, placing decision making with service users and carers. To proactively

move away from an existing service culture of dependence on service provision to achieve individual goals and to promote independence.

- To be responsible for ensuring that the Promoting Independence Commitment Statement is fully signed-up to by all staff in order that it is identified as part of the performance framework.

- To develop new and innovative ways of doing things recognising and promoting the positive benefit of change to improve services and achieve goals. To promote a culture of organisation learning across the whole service encouraging constructive challenge and learning by mistakes.

- To consider the wider implications of issues during the business planning process and conclude with a realistic and thorough assessment of risk including mitigating actions.

- To be responsible for ensuring that robust information systems are in place and maintained across health and social care, including the sharing of data with health partners such as GPs. To analyse information to identify priorities, make decisions, determine action and review progress.

- To be responsible for ensuring that the work carried out by all functions in the integrated learning disability service are in accordance with required Council standards and standing orders, legal requirements and national and local objectives and that adequate monitoring and auditing processes are in place.

Communication

- To communicate in a confident, informed, and authoritative manner, in line with established policies, practices and priorities of the Council in order to maintain and enhance organisational credibility.

- To demonstrate full commitment to the development and updating of Easy Read documentation for the main areas of service activity such as assessment and service development.

- To be responsible for ensuring that communication to stakeholders regarding development and activity of the integrated service meets the requirements of a diverse audience including those with multiple needs such as Profound Learning Disability

Leadership and the Management of People

- To develop a fully integrated service, promoting open communication, clear direction and the creation of a performance oriented approach and culture. To ensure that

appropriate workplans, appraisal, supervision and staff development systems are in place to achieve Council departmental and service strategies and objectives.

- To be responsible for ensuring that the workforce are aware of standards, expectations and timescales, and to establish clear lines of responsibility and accountability building trust, good morale and teamwork.

- To manage the services in a manner that promotes equality of opportunity and collaborative working within staff teams; ensuring that staff are aware of the requirement to deliver non discriminatory services and to promote greater equity for disadvantaged groups.

- To effectively liaise, plan and deliver agreed outcomes with other Heads of Service across Adult Social Care. To work as part of the senior management team to support the Director and Group Director as required

- To consistently promote and apply the Council's Human Resources Standards and Equalities Standards and to ensure that this is demonstrated and maintained throughout the service.

Political Sensitivity and Personal Effectiveness

- To have an awareness of the political context and commitment to the Council's organisational values and beliefs.

- To brief the DASS, Director of Adult Social Care, and relevant S75 lead partners of any potential issues arising from service delivery or workforce activity across all services which may negatively impact on organisational reputation.

- To ensure that feedback on the integrated team is utilised in planning and service development. To ensure that complaints are dealt with effectively and within agreed timelines.

- To be political sensitive, be able to recognise and deal with a range of strategic political and sensitive issues that impact on the service area.

- To create personal priorities and targets with agreed outcomes and deadlines while maintaining a grip on the key priorities/accountabilities

Managing Projects and Resources

- To fully understand budget making processes, and demonstrate ability to set and manage a significant budget. To deliver high quality value for money services and agreed savings.

- To be responsible for the integrated Learning Disability service budget, reporting to governance Boards such as the Section 75 on unplanned variance and mitigating actions. To lead on the management of all resources allocated to the service within the regulations of the Council ensuring appropriate monitoring to avoid overspends.

- To be responsible for ensuring that all projects are managed within the Constraints of current legislation, Government Directions and the Council's approved management practices. To apply effective project management techniques where required.

- To promote and agree performance indicators that are based on outcomes and be responsible for achieving performance targets for the service.

- To deputise for the Director within the functions of the post holder's responsibilities and to work collaboratively with Heads of Service to manage the overall work of Adult Social Care services.

- To provide senior managerial cover for other parts of Adult Social Care in the short-term absence (annual leave/sickness) of substantive post holders.

- To represent the Division on working groups, conferences etc. concerning Adult Social Care and to commit staffing and resources within the responsibility of the post holder in order to meet agreed objectives.

- To be responsible for the development of policies for Learning Disability in respect of Adult Social Care including chairing working groups, taking a lead role on inter departmental and inter agency work and initiating developments designed to ensure a high quality integrated health and social care service to people with a learning disability.

- To be responsible for ensuring that new national guidance and policy directives are implemented into operational practice; including the preparation of appropriate guidance to staff, local policies and practice directives and advise to elected members and other departments.

- To initiate policies and processes that will improve overall service delivery to those in need of services, maximising an inter agency approach and new funding opportunities.

- To work in close collaboration with Commissioning to ensure that the overall commissioning and service planning approach is informed by user profiling and need.

- To demonstrate understanding of the purchasing requirements of the Section 75 partners and to inform them of any changes to the specification of the integrated Learning Disability service.

- To prepare and present reports and working papers relating to Learning Disability at Committee, management briefings and inter agency forums.

- To be responsible for ensuring that the development and delivery of services reflect policy directives, good practice and local priorities and that the need of Hackney's socially and ethnically diverse communities are appropriately addressed.

- To advise on and make decisions in respect of complex cases requiring the agreement and/or expertise of a senior manager; taking appropriate advice from legal services as appropriate and to represent the Service in Court hearings if required.

- To be responsible for the establishment and maintenance of auditing systems which ensure adequate comprehensive recording practice, assessment and case management arrangements.

- To chair departmental and inter agency panels and agree courses of action following decisions on the allocation of resources.

- To plan for, participate in and act on the findings of internal and external inspections of services to People with a Learning Disability.

Person Specification

POST TITLE:	Head of Integrated Learning Disability Service
DIRECTORATE:	Health and Community Services
SERVICE:	Integrated Learning Disability and Direct Payments
GRADE:	SM1
LOCATION:	London Borough of Hackney
RESPONSIBLE TO:	Director – Adult Social Care and Commissioning
RESPONSIBLE FOR:	An Integrated Learning Disability Service across Health and Social Care

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People Skills and Leadership

- Track record of strong and effective leadership, with proven ability to provide vision and direction to individuals and teams so as to gain ownership and commitment.

- Able to demonstrate a track record of standard setting for staff and managers and including, expectations, timescales, and establishing clear lines of responsibility and accountability

- Ability to motivate and empower managers and staff so as to build effective teams and relationships, trust, good morale and teamwork.

- Ability to attract, develop and retain a highly motivated and professional workforce and to deal swiftly and competently with any performance issues or unprofessional conduct.

- Ability to ensure staff demonstrate service performance by the timely and accurate recording and use of IT systems, as required by the department and partners.

- Able to demonstrate a track record of managing services in a manner that promotes equality of opportunity and collaborative working within staff teams; ensuring that staff are aware of the requirement to deliver non discriminatory services and to promote greater equity for disadvantaged groups.

Strategic Thinking and Planning

- Able to demonstrate a track record of strategic planning and the delivery of high quality customer services.

- Demonstrate the ability to devise strategies for the service area and translate them into realisable plans

- Able to demonstrate a track record of applying strong analytical skills and laterally thinking to develop creative and innovative service solutions.

- Ability to apply findings from research evidence and best practice

- A strong track record of developing and delivering within a performance management culture.

- Demonstrable experience in ensuring service outcomes to agreed standards by timely and accurate recording of performance data as required by Section 75 partners and stakeholders.

- Ability to manage and direct major service delivery initiatives and projects from inception to implementation within budget and set timescales.

Financial and Resource Management

- A clear understanding of budget making process and has proven ability to manage a significant budget to the standard required by the Council, whilst delivering high quality, value for money services.

- Experience of managing complex budgeting processes within Health and Social Care settings.

- A clear knowledge and understanding of commissioning processes in Health and Social Care and experience of operating within a Section 75 agreement.

Personal Style and Behaviours

- Personal and professional demeanour which generates credibility and confidence amongst customers, Members, chief officers, managers, staff, external partners and all other stakeholders.

- Excellent communication skills both oral and written with experience of composing Board reports and presentations for a wide audience including senior personnel across the London Borough of Hackney.

- IT competent and be able to interpret data, to constantly improve performance and manage standards in the service.

- Able to set personal priorities, objectives and deadlines while maintaining a focus on the key service priorities/accountabilities.

- Ability to acquire new skills and demonstrate a strong commitment to learning/continuous professional development for self and others.

Political awareness/sensitivity and appreciation of the wider context

- Able to demonstrate political awareness with the ability to build positive relationships with elected members to balance political drivers with strategic priorities.
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- Able to evidence understanding of Corporate objectives, Government directives Social Care policy and emerging Health and Welfare reforms

- Experience of managing strategic governance arrangements of learning disability services which includes service user and carer involvement as well as statutory and voluntary organisations.

▪ **Qualifications and Experience**

- A degree qualification or above in either: Social Work, Social Care, Nursing, Allied Health profession or Public Health

- Track record of strong and effective leadership with proven ability to provide vision and direction to individuals and teams so as to gain ownership and commitment.

- A strong track record of developing and delivering within a performance management culture.

- Significant and relevant managerial experience within health and social care systems and services for people with learning disabilities

- Sound experience of delivering and managing complex projects

- Experience of effectively managing extensive and complex budgets
- Experience in change management.

- Senior management qualification would be desirable.
- Desirable experience of working within an integrate service setting
- Understanding of the key current policy directives for adult social care and health.

APPENDIX 5

Service Specification: Integrated Learning Disabilities Service

Service Specification

Service Specification No.	XXX
Service	**Integrated Learning Disabilities Service**
Commissioner Lead	Joint Strategic Commissioner for Learning Disabilities
Provider Lead	London Borough of Hackney / East London Foundation Trust
Period	April 2019 – April 2024 Plus option to extend plus one, plus one.
Date of Review	Annual

Service Specification: Integrated Learning Disabilities Service

1. BACKGROUND

A learning disability is a reduced intellectual ability and difficulty with everyday tasks e.g. daily activities, socialising which affects someone from childhood. Someone with a learning disability takes longer to learn and may need support to develop new skills, understand complicated information and interact with other people. The Service detailed in this specification is for a specialist health and social care service, working together, for people with a learning disability.

There are approximately 1.5million people with a learning disability in the UK. In England (2011) 1,191,000 people were estimated to have a learning disability. This included 905,000 adults aged 18+ (530,000 men and 375,000 women) – *Source: People with Learning Disabilities in England (2011).*

People with learning disabilities are more likely to be deprived and experience inequalities in their health than the general population. For example, people with a learning disability are four times more likely to die of something which could have been prevented than the general population (Disability Rights Commission, 2006). They are often a very vulnerable group in society.

2. National Policy & Frameworks

2.1 Valuing People (2001) and Valuing People Now (2009)

Valuing People remains the key and most recent national policy framework for learning disabilities. Many of the key principles of Valuing People and Valuing People
Now (2009) are now enshrined in the Care Act 2014. Our commissioning intentions reflects these, and other key priorities described in Valuing People Now.

2.2 The Care Act (2014)

The Care Act sets out a vision for a reformed support system, ensuring health and social support is focused on people's wellbeing, prevention and supporting people to stay independent for as long as possible and lays out what local authorities must do. E.g.:

- carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care
- focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve

- involve the person in the assessment and, where appropriate, their carer or someone else they nominate
- provide access to an independent advocate to support the person's involvement in the assessment if required
- consider other things besides care services that can contribute to the desired outcomes (e.g. preventive services, community support) use the new national minimum threshold

It requires Local Authorities to identify the individual's strengths – personal, community and social networks – and maximise those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving or maintaining their wellbeing. The Act also gives people the legal right to a 'personal budget' and or a 'personal health budget'

It is expected that the Service will be Care Act compliant.

Source: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

2.3 Transforming Care & Building the Right Support (2015)

Building the Right Support is a national plan to develop community services and limit admissions for people with a learning disability and/or autism who display behaviour that challenges.

It identifies what good services and support looks like for people with a learning disability and/or autism who display behaviour that challenges, including behaviours which may result in contact with the criminal justice system. It is structured around nine core principles:

1. People should be supported to have a good and meaningful everyday life
2. Support should be person-centred, planned, proactive and coordinated
3. People should have choice and control over how their health and care needs are met
4. People with a learning disability should be supported to live in the community with support from and for their families/carers as well as paid support and care staff
5. People should have a choice about where and with whom they live
6. People should get good support from mainstream NHS services, using NICE guidelines and quality standards
7. People with a learning disability and/or autism should be able to access specialist health and social care support in the community

8. When necessary, people should be able to get support to stay out of trouble
9. When their health needs cannot be met in the community, they should be able to access high-quality assessment and treatment in a hospital setting, staying no longer than they need to

There are 'golden threads' that run consistently through these principles:

• Improving quality of life

• Keeping people safe

• Promoting choice and control

• Support and interventions should always be provided in the least restrictive manner.

• Equitable outcomes, comparable with the general population, by addressing the determinants of health inequalities.

(*Source:* Building the right support, LGA, ADASS, NHSE, October 2015)

The Service is expected to work within these policies, legislation and frameworks.

2.4 NHS long Term Plan

The NHS long term plan specifically mentions learning disabilities including Transforming Care and preventing premature deaths through addressing health inequalities e.g. through improving health checks and NHS services making reasonable adjustments for those with learning disabilities. It outlines intentions to improve health and care services better so that more learning disabled people can live in the community, with the right support, and close to home with a view to preventing hospital admissions where possible. It also identifies the need for timely diagnosis and access to specialist services. The Service is expected to support with implementation of this plan.

3. Local Context

Health and social care organisations in Hackney and the City of London are increasingly working together more to try to improve residents' health and wellbeing.

Hackney is a diverse inner London borough, with significant 'Other White', Black and Turkish communities; e.g. the Charedi Jewish community is concentrated in the North East of the borough and is growing. It is a relatively young borough with a quarter of its population under 20. Services need to consider such diversity as part of their work.

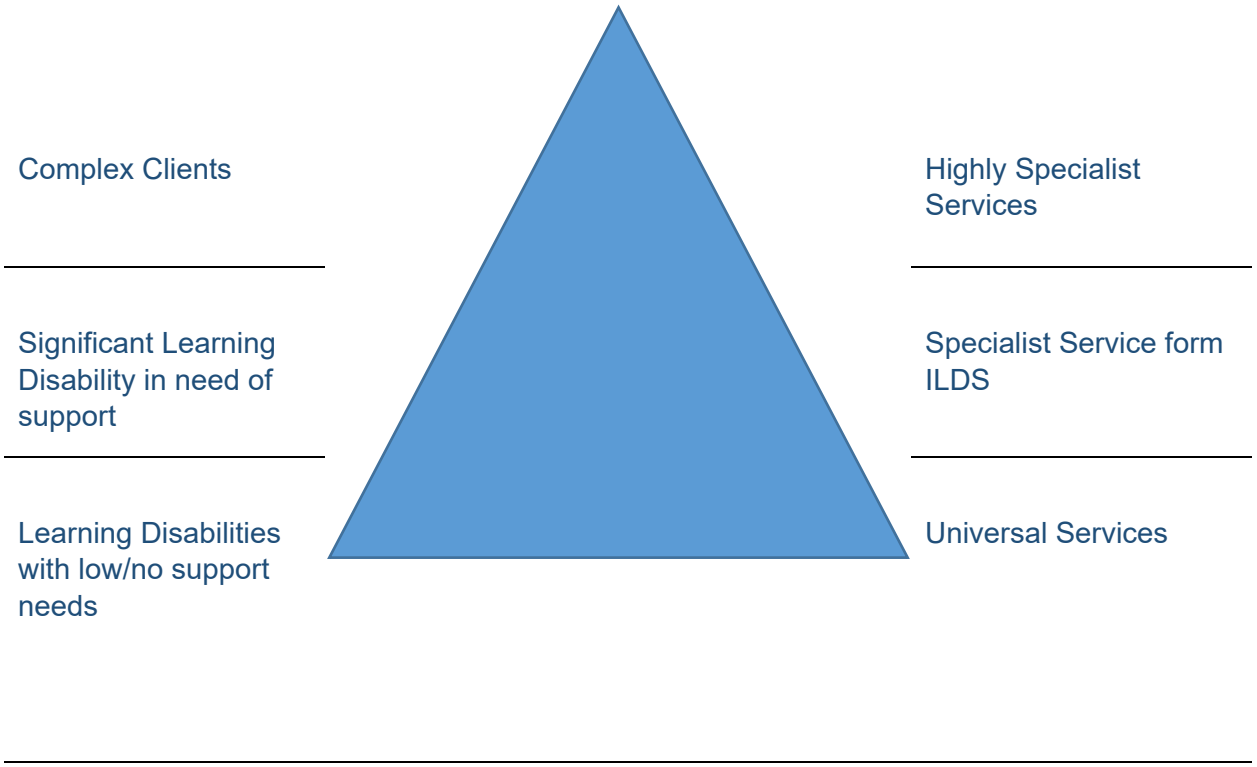
Hackney's population is estimated at 263,150 people. Approximately 2.4% of adults in the City and Hackney population have a learning disability; this equates to 4,937 people in Hackney and 177 people in the City in 2015.

Information from City & Hackney's Joint Strategic Needs' Assessment JSNA (2017) identified the following:

- Approximately 2.4% of adults in the City and Hackney population have a learning disability; this equates to 4,937 people in Hackney and 177 people in the City in 2015.
- The size of the local adult learning disabled population is expected to grow by around 900 people (or 17%) to 2030. Around 200 people are expected to be living locally with a moderate/severe learning disability by 2030.
- The greatest proportion of adults with learning disability in contact with local services are classified as British/White British/Mixed British/English (around 30%). A relatively high proportion of adults receiving a care package in Hackney identify as Jewish.
- The largest number of people affected by learning disability are estimated to be in the 25-34-year age group. This is due to the relatively young population in Hackney as well as the higher prevalence of learning disability in younger people.
- Many have comorbid conditions. For example, there are significantly higher rates of serious mental illness (SMI) in adults with learning disability, around 14% of learning disabled patients affected locally (in comparison with around 1% of the total adult patient population). Provisional national data indicates that local rates are higher than might be expected (around 9% of learning disabled patients nationally coded with SMI).
- People with a learning disability are more likely to be living in the most deprived local neighbourhoods compared with the total population.
- Almost one quarter (22%) of adults with a learning disability are estimated to have a moderate or severe condition.
- Adults with learning disability who are in contact with social care services are unlikely to be in paid employment. In Hackney, the employment rate is significantly lower than comparable areas in London (Hackney rate 2.9%, CIPFA comparator group rate 6.2%).
- Around 40% of adults with learning disability are estimated to be living with their parents. This is much more common in younger age groups. The predicted ageing of the local adult learning disabled population is likely to create additional support and housing needs over the next 15 years and beyond.
- Overall, almost 40% of learning disabled adults with a care package in Hackney are in residential or nursing care; almost all of these adults are placed out of borough.
- Local learning disabled adults are at significant risk of social isolation.

City & Hackney JSNA (2017)

It is expected that most people with learning disabilities will be accessing universal services. For some their needs may go up and down, dipping in and out of specialist services.



A series of consultation exercises was undertaken with people with learning disabilities, carers, the Integrated Learning Disabilities Service and other stakeholders (2017-18). This service specification has been developed to include the feedback and findings from these exercises.

Some work has already been undertaken on shaping the Service Pathways of the Integrated Learning Disabilities Service (referred to as 'the Service'), and this work is expected to continue in order to meet the requirements of this schedule.

4. OUTCOMES

4.1 Outcomes Framework Domains & Indicators

The Service will work towards the following outcomes as laid out in the national Adult Social Care; NHS and Public Health outcomes framework:

Domain 1	**Preventing people from dying prematurely**	

Domain 1	**Preventing people from dying prematurely**	
Domain 2	**Enhancing quality of life for people with long-term conditions**	
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

Please see Appendix 1 for Outcomes based on the above domains and ASCOF etc. which are matched to the service delivery.
The service will work as part of the overall Learning Disabilities Strategy for City and Hackney, supporting it to achieve its outcomes.

As a specialist, adult, community learning disabilities service, the overall goal of the service will be:

> *To ensure people with learning disabilities achieve their potential, are as independent as they can be, have a good quality of life, and equal life opportunities to anyone else.*

4.2 KEY OUTCOMES

The Service shall work to achieve the following local (coproduced) key outcomes:

- **People with a learning disability are an active part of their community**
- **People with a learning disability are enabled to achieve independence where possible**
- **People with a learning disability have a place they call home**
- **People with a learning disability are able to access the health care they need.**

A theme of safety shall run throughout these

4.1 AIMS/ PRINCIPLES OF THE SERVICE

The key principles as laid out in Valuing People and Valuing People
Now (2009) will be a constant theme across the Service. The Service will work to ensure

1. People with learning disabilities and their families have the same human rights as everyone else.
2. Choice and control are promoted in all aspects of the lives of people with learning disabilities, including their services and support.

3. People with learning disabilities are enabled to be as independent as they can be, whilst ensuring their personal safety, and freedom from discrimination.
4. People with learning disabilities lead fulfilling lives and participate in all aspects of community life – work, learning, be part of social networks and accessing goods and services.
5. People with learning disabilities will have good health and wellbeing.
6. People with learning disabilities and their carers are at the centre of everything the service does.

4.3 OBJECTIVES:

The Service will ensure that it is able to demonstrate positive outcomes for people with learning disabilities as a result of its work through achievement of the following objectives:

- An increase in the number in paid employment and an increase in volunteering activities.
- A reduction in residential placements and an increase in those living in their own home/ with a tenancy.
- An increase in the uptake of mainstream and universal services and activities.
- A high uptake of health checks and screening.
- An increase in the number of healthy behaviours/ or health promoting activities.
- A reduction in health inequalities.
- Avoidance of unnecessary admissions to hospital.
- Safe, planned and effective discharge from hospital.
- A reduction of social isolation.
- A feeling of safety among people with learning disabilities in their community.
- A reduction in the need for support.
- Good quality service provision for people with learning disabilities.
- An increase in Personalisation.

Key performance indicators are listed later in this Specification.

5. SERVICE MODEL

The Service will be an integrated service of health and social care partners working together to provide a holistic approach to meeting the needs of people with learning disabilities. It will be needs led but with enabling strengths-based approaches. The Service will use specialist knowledge and skills, evidenced based and best practice to work in a multi-disciplinary way.

There will be a clear pathway/s including overall access into and out of the service.

The Service will support people with learning disabilities to achieve their goals, aspirations and full potential. It will work in collaboration with people with learning disabilities, their carers and others to enable the individual with learning disabilities and/or build the right support around them; ensuring good health and wellbeing.

The Service shall support people with learning disabilities to have the same rights and responsibilities as everyone else, supporting with reducing or removing the barriers faced by people with learning disabilities. This will include supporting positive risk taking.

The Service will work towards delivering the right support at the right time in a joined-up manner, so that people with a learning disability have positive experiences of support. This will include supporting smooth transitions, including at the time of preparation for adulthood and end of life.

The Service should use an outcomes-based model which provides greater choice, control and flexibility for those accessing services. This includes using a range of mechanisms such as Direct Payments, Personal Health Budgets and Individual Service Funds. The Service will support with ensuring good value for money services for people with learning disabilities.

6. KEY FUNCTIONS

The key functions required for delivery by the Service are to:

- Work in partnership with others, such as mainstream services, to ensure equal and fair access and advice on reasonable adjustments for people with learning disabilities.
- Assist people with learning disabilities and those supporting them to better understand the causes of ill-health, support to access to good primary care, community and specialist acute/mental health services, and wider mainstream opportunities in society.
- Respond positively and effectively to vulnerable people in need of support and ensure a smooth transition of eligible clients into the Service
- Offer a timely service which adheres to health and social care requirements.
- Provide effective integrated, person-centred support to people with learning disabilities
- Assess and meet the needs of people with a diagnosed learning disability, including young people transitioning into adulthood, using a coordinated and integrated approach.
- Provide direct specialist clinical, therapeutic and social care support for people with a learning disability
- Deliver individual outcomes as part of assessment and support planning processes.
- Ensure that individual service user Reviews are meaningful, timely, of high quality, and outcomes focused.
- Offer a holistic approach to care and support of the individual
- Involve people with learning disabilities and their carers in key decisions about service delivery and support.
- Deliver a specialist service in line with up to date best practice

- Work with Commissioners to identify gaps and develop service options appropriate for people with learning disabilities in the borough.
- Attend, inform and deliver the priorities of the Learning Disabilities Partnership Forum.
- Support and engage with key programmes that support people with learning disabilities to have better lives. This includes work on the Transforming Care Programme to avoid admissions.

Broadly these functions fall into three main roles for the service:

1. **Advice, Consultation, and Signposting**:

   This works on the principles that people with learning disabilities should be able to access the same opportunities and mainstream/universal services as anyone else in the population. The Service will work to ensure this through provision of advice, guidance in a consultative role. This will include providing accessible information and signposting to other services. The Service will work to address the inequalities experienced by people with learning disabilities more widely; developing positive relationships with other services is key to making this happen. Unlike the other roles, the service will focus on the environmental factors.

2. **Prevention, Enablement and Promotion of Independence:**

   Working in a person-centred, way the service will work to develop the strengths of individuals with a learning disability to support them to achieve their full potential and, where possible, prevent the need for further services. This will tend to be shorter term, discreet outcomes focussed pieces of work.

3. **Complex and Longer-Term Specialist Cases:**

   Working in a person-centred way, the service will work to develop the strengths of individuals with a learning disability to support them to achieve their potential, maintain ability and ensure a good quality of life.

Some people with learning disabilities will use these discreet service roles, however, there may be those who need different aspects of these roles at different times and there may be some crossover. These roles will be undertaken in order to meet the service outcomes and via the pre-agreed integrated pathways.

PERSON CENTRED PRACTICE

The Service will be person-centred and accessible in all aspects demonstrating a commitment to be flexible, sensitive and responsive to the individual's needs and preferences whilst ensuring client choice and informed risk taking. Adhering to the following principles:

- Put the person at the centre
- Give the person choice and control and support them to be a valued Citizen and part of their community
- Ensure the person is respected, listened to and their rights upheld
- Ensure the person's voice is heard, even if they can't say, or express themselves
- Use an outcome focused approach, enabling the person to achieve their goals
- Support planning tailored to each person's unique needs and wishes, is fully accessible and is ever evolving
- Include people who know the person best, to help plan support and recognise the contribution families can provide as experts
- Start with the resources already available within the person's life and wider community and then identify where 'just enough' support is needed to bridge any gaps
- Start planning for the future as early as possible
- Involve the person and their family in choosing who supports them, seek to match people with the right support staff

The Service will be committed to partnership working with service users and their families. Where possible and requested, the Service is expected to offer personalised approaches to meeting service user outcomes.

The Service needs to recognise that there are often complex and stressful demands upon carers and should ensure that the statutory requirements for the support of both service users and carers are met in line with the Care Act (2014).

7. Scope of the Service

The Service is commissioned jointly through the London Borough of Hackney (LBH or the Council) and the NHS via City and Hackney Clinical Commissioning Group (CCG). It will be provided by LBH and East London Foundation Trust (the Trust).

This Integrated Learning Disabilities Service (The Service) will provide specialist health and social care services for adults with a learning disability and for young people Preparing for Adulthood to meet the health, social care and wellbeing needs of people with learning disabilities and their carers.

The Service will be accessible to any person with a learning disability and who meets any one of the below criteria:

- Is registered with a GP in City or Hackney.

- Is assessed as eligible for NHS Continuing Healthcare under City and Hackney CCG

- Is an ordinary resident of Hackney

(See also Section 10: Access to the Service for further information on diagnosis)

The Service will work to improve health and wellbeing, use preventative approaches wherever appropriate and enable people to live as independently as possible.

The Service must be a highly specialist service in order to provide direct specialist clinical, therapeutic and social care support for people with learning disabilities including those with complex needs.

In order to deliver high-quality person-centred care, continuity of care and coordinated support it is essential that care pathways are fully integrated to ensure good outcomes are achieved.

The Service will provide time limited, person-centred assessment, care management, care coordination, therapeutic intervention, monitoring and health professional training and support for people with learning disabilities and their carers in a range of settings.

Delivery of the Service will support social inclusion, access to mainstream and universal services; valuing equality and diversity.

The Service will support access to:

- Timely and meaningful diagnostic support and input.
- Individualised tailored care and support plans which are outcomes-focused.
- Personalised services including Personal Health Budgets
- A safe environment designed to meet the person's holistic needs
- Meaningful accessible information to navigate through services
- Well trained staff regardless of where people receive services
- Service user choice to design own services
- Personal Health/Care Plans based on service user need and wishes and not on how services are designed
- Accommodation that is right
- Support from the community (other teams & providers)
- Information, advice and support for carers
- Specialist support for behaviours that challenge, including Positive Behaviour Support
- Education
- Employment

The Service shall work in partnership with other organisations where appropriate to ensure suitable access to the above.

The assessment, treatment and care planning of interventions will be provided through a multi-disciplinary team.

The multi-disciplinary Service will deliver a wide range of specialist support, including via the following disciplines:

- Social Work
- Speech and Language Therapy (SALT)
- Physiotherapy
- Occupational Therapy
- Nursing
- Psychology
- Behavioural Therapy
- Psychiatry
- Approved Mental Health Practitioners/ Social Supervisors

8. Enabling Access to and Responses from Mainstream Services

Outcomes:

People with learning disabilities will be able to access the services they need.

Enhancing quality of life for people with long-term needs and improving the wider determinants of health.

The Service is required to engage in strategic development work that supports better universal access to community and mainstream services and positive outcomes reducing known health and other inequalities. The Service will be a key resource to enable mainstream health and care services to make reasonable adjustments for learning disabled people; it will have a consultancy role for mainstream services when required. This will include involvement in planned programmes of:

- multi-agency training
- education,
- mentoring
- informing
- consultancy to others about responding to the needs and concerns of people with learning disabilities.

The Service should also provide on-going support, supervision and advice to services (especially primary, community, specialist acute/mental health and criminal justice services) to support them in:

- Establishing joint registers and flagging systems for all known local patients with learning disabilities, thereby enabling the provision of 'reasonable adjustments' and positive support plans that mitigate known health inequality and service access outcomes

- Ensuring regular dialogue and joint training meetings with mainstream health and social care services to discuss any particular general concerns and support plans
- Developing increasing confidence, skills and experience in supporting patients with complex health support needs through training and other service development interventions.

Priority should be given in relation to supporting key target groups where awareness and understanding of learning disabilities will be critical to achieving high quality health and social care outcomes for service users and carers.

9. Addressing Health Inequalities

Outcomes:

People with learning disabilities will have equal access to health services and experience good health and wellbeing.

Preventing people from dying prematurely

Health Facilitation and liaison is an important function of the Service to address the inequalities experienced by people with a learning disability and prevent premature death. It includes direct work, supporting individuals to make informed choices about their health needs and supporting local health services to be more accessible to those with a learning disability. The Service will in future link in with the proposed Neighbourhoods Model in the borough.

Annual Health Checks can identify health conditions, ensure the appropriateness of on-going treatments, promote health (e.g. screening/ early immunisation) and establish trust and continuity of care. All patients with a learning disability should be on a learning disability register in their general practice and, once aged 14 and over, should have an annual health check and referred/supported to receive appropriate actions, such as lifestyle advice and sexual health. It is imperative that practices are helped to make reasonable adjustments and provide appropriate support materials; the Service is expected to support with this.

The Service needs to develop its health facilitation and liaison role to meet the following objectives:

- To support delivery of Annual Health Checks and Health Action Plans, in GP practices/primary care
- Be responsible for ensuring that everyone known to them and registered with a GP as having a learning disability is offered a Health Action Plan. This will require working closely with all other providers of care for people with a learning disability.
- Identify known gaps in the provision and delivery of Health Action Plans and ‘Reasonable Adjustments’ by generic providers to improve access to health care for people with Learning Disabilities and to inform Commissioners
- Implementation of the Health Equality Framework (HEF) or similar to demonstrate measurement and achievement of user outcomes.
- Support equal access to screening programmes and to ensure safe and clinically effective access to primary and secondary care.

- Support local NHS providers to communicate their services in accessible formats and make reasonable adjustments for people with learning disabilities to access their services.
- Ensure hospital passports are available and used
- Provide awareness raising, education, training and support to statutory generic NHS providers to make reasonable adjustments and develop accessible information.
- Provide proactive leadership in facilitating better coordination of care and improved patient experience involving specialist and mainstream healthcare.
- Enabling Others to Provide Effective Person-Centred Support to People with Learning Disabilities
- Provide specialist advice, limited support and client-specific training to people with learning disabilities, families, carers and service providers across the statutory, independent and voluntary sectors
- Establish a detailed understanding of all local resources relevant to support individuals with learning disabilities and their families/carers and promote effective integrated working maximising the health and well-being outcomes of individuals and the local community.
- To actively participate in the LeDer (prevention of premature deaths) Programme

9.2 LEDER

The Learning Disability Mortality Review (LeDeR) Programme was established as a recommendation from the Confidential Inquiry into the premature deaths of people with learning disabilities. People with learning disabilities continue to die earlier than people without learning disabilities and in many cases the death may have been prevented with earlier diagnosis and prompt treatment.

Its aim is for local areas to review all deaths in someone with learning disabilities aged 4 and over to learn lessons from the case and implement change in practice.

The Service will be part of the local LeDer arrangements and contribute to these reviews. The service is expected to have a minimum of two LeDer trained Reviewers who can undertake allocated reviews and the service will undertake a minimum of three LeDer reviews a year (Appendix IV) and report on this as part of performance monitoring. Please see the guidance on the LeDeR process http://www.bristol.ac.uk/media-library/sites/sps/leder/Guidance_for_the conduct of reviews_FINALv2.2.pdf

Key Partnerships Include…
Primary Care, Acute Hospitals, Mental Health Services, Social Care agencies, Police, Probation; Job Centre Plus; Community Services; Public Health

10. ACCESS TO THE SERVICE

Outcomes:

The Service is accessible to people with learning disabilities.

People with learning disabilities and their carers find it easy to find information about support

The starting point should be mainstream services (which should be available to all) to support people with a learning disability, making reasonable adjustments where needed and accessing specialist expertise as appropriate. However, there may be some who require more specialist support.
This Service is specialist to people who have a learning disability.

10.1 Population Covered

People who meet the criteria for a diagnosis of learning disability are an extremely varied group.

Access to the service will be by formal diagnosis. Evidence of all three of the following criteria must be met for a person to be considered to have a Learning Disability (British Psychological Society, 2000).

DIAGNOSTIC CRITERIA FOR LEARNING DISABILITY

1. Significant impairment of intellectual functioning (e.g. an intelligence quotient (IQ) of below 70, etc.)

2. Significant impairment of adaptive/social functioning (e.g. Score below the Process Cutoff on the Assessment of Motor and Process Skills)

3. Age of onset before the age of 18 (e.g. Statement of Special Educational Need; attendance at a special school; childhood medical reports).

The ILDS will provide a service to people who meet the learning disability diagnostic eligibility criteria as detailed above and who have an eligible health and/or social care need.

The Service shall ensure that the religious, cultural and spiritual needs and wishes of all Service Users are identified, respected and wherever possible met.

REFERRALS

The Service will operate a single point of access (SPA) for all referrals. All referrals will be screened for evidence of a learning disability. Screening will be done in a timely way along with responses to referrers.

If the evidence provided is inconclusive of a learning disability, the Service will offer a Learning Disability Diagnostic Assessment and will only proceed to complete a full Single Assessment once eligibility for the service has been determined.

Where there is no evidence of learning disability or it is concluded that a person's needs can be better met by mainstream services the person and/or referrer will be given information, advice and /or signposted to appropriate support to meet their needs in line with the Care Act, 2014.

If the person referred has urgent health or social care needs (e.g. safeguarding, imminent placement breakdown, immediate threat to person's physical health or safety or those around them) their referral will be discussed with seniors in the Service as soon as the referral is received and a plan will be agreed on the day and communicated to the referrer. Consequently, there may be instances of the Service working with people who it is later concluded do not have a global learning disability.

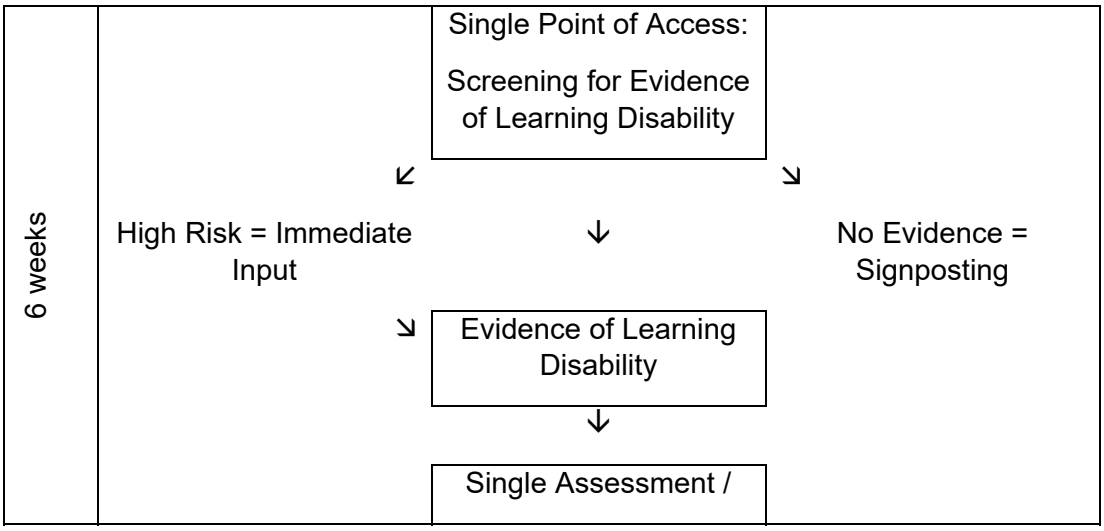
If there is evidence of learning disability the person referred will be offered a Single Assessment of his/her health and social care needs.

People who are already known to the Service will be offered a new Single Assessment if their living circumstances have changed or if they have not had a service from ILDS for at least three years.

If a new Single Assessment is not required, the referral will be passed straight to the most appropriate discipline(s) for the needs identified in the MDT referral discussion.

All referrals should be discussed at multidisciplinary team meeting to ensure a co-ordinated approach between disciplines and to avoid any duplication. All referrals should be prioritised according to levels of risk and urgency.

New adult referrals will receive initial joint multidisciplinary comprehensive single assessment' within 6 weeks of referral by the Service.



		Referral to Appropriate Discipline	

(Further information about the pathway through the Service can be found in 17. Processes & Procedures)

10.2 Preparation for Adulthood

Outcomes:
Young people with learning disabilities and their carers are involved in person-centred planning; they have a positive experience of care/support and transitioning between services.

The Service will support high quality person-centred transition planning as part of preparation for adulthood. Young people and their families should have a strong/the strongest voice at all meetings and planning concerning them. They should be expected and encouraged to say what is positive in their lives and what is possible in their future and know that clear guidance has been given and actions set in key areas of their lives.

Young people should be supported to be aware of local opportunities and options regarding housing and community involvement, and such aspirations should be encouraged in the planning process. Transition should be based upon the idea that people with learning disabilities will live in inclusive communities and be supported in those communities.

Planning however should reflect individual circumstances and the Service will need to be aware of what the options are and how to help with accessing them e.g. Hackney's Local Offer.

The Service will need to ensure effective communication and mechanisms are in place to support a smooth transition into the Service. This includes the recommendations as laid out in NICE Quality standard (QS140) - Transition from children to adults' services which describes high-quality care in priority areas for improvement.
https://www.nice.org.uk/guidance/qs140

The Service will:

- Support effective Education, Health and Care Planning of people with learning disabilities.
- Ensure best practice is used when young people with learning disabilities are transitioning into adult services e.g. planning should start from age 14 or before.
- Work in line with the Transforming Care Local Protocol for service user aged 14+years.
- Ensure timely decision making about if and how the young person will be supported.
- Support young people into adulthood with paid employment where possible, good health, independent living options and friends, relationships and community inclusion.
- Ensure involvement in personalised annual reviews the school, family, representatives from the council and professionals will get together with the young person to identify the most appropriate pathway, enabling them to achieve their outcomes.

- Support with risk management especially those associated with young people e.g. online safety and gang culture.
- Agree short and long term outcomes to support the progress of the young person in meeting their educational and career aspirations including the areas of:
  - Higher Education, training and/or employment.
  - Independent living
  - Participating in society
  - Being as healthy as possible in adult life

Key Partnerships Include…
Children's Health and Social Care Services e.g. Children and Adolescent Mental Health Services, The Ark; The Learning Trust; Support Providers; Prospects; Colleges

11 Prevention, Enablement and Promotion of Independence

The Service will take a strengths-based approach and ensure that there is service provision for people with learning disabilities to develop their independent living skills and achieve their potential. This should prevent the need for longer term care and support.

The Service will enable people with learning disabilities to make healthier choices and improve their health and wellbeing adopting an approach of Making Every Contact Count (NHS Health Education) in interactions with service users and their support. It will strive to address the socioeconomic inequalities faced by people with learning disabilities, including through improved social integration, support to access employment, joined up working with other services/agencies, and planning ahead from an early age to achieve positive outcomes.

The Service will be able to demonstrate individual outcomes for service users through appropriate measures, e.g. the Health Equalities Framework or similar.

CRISIS PREVENTION

Crises are usually predictable; the Service should work proactively to prevent crisis situations for people with learning disabilities. One such mechanism is a risk register whereby risks are rated and stratified. The Transforming Care register should be used for this purpose and pro-active prevention of unnecessary hospital admissions by the Service. Senior members of the Service should be identified as responsible for leading on maintaining and updating such registers but using MDT approaches. If a crisis does happen, the Service should ensure the right sort of help/support is available to rapidly defuse and stabilise the situation/s. Suitable recording mechanisms also need to be in place.

The Service needs to ensure there are appropriate systems is in place, such as Duty or similar, to deal with urgent issues that arise in relation to service users, new enquiries or referrals. It should also deal with unallocated cases to prevent or manage crises in a timely and expert manner e.g. where the allocated/named worker is unavailable.

For service users known to experience crises, the Service should ensure a well thought out contingency plan is in place, which should assist the effective management of emergency and demanding situations.

The Service will deal effectively with crisis, responding on at least 3 levels:

- Proactive crisis prevention
- Reactive crisis management and immediate resource deployment
- Proactive Strategic planning and service development (informed by the first 2 levels)

The Service will retain accurate up-to date knowledge about all those locally with severe support reputations e.g. challenging behaviour, and their histories of crisis situations, and work proactively to prevent crises. The Service should ensure partnership working with others around the identified individuals to support this.
It should make sure the right support is available at the right time, including:

- Comprehensive summary assessments are already in place for all clients in transition, family homes and agency placements – critically defining the things that help and make things worse
- Positive health action and behaviour support plans (with potential crisis situations identified and clear relapse prevention plans) for the individuals with severe reputations at any point in time clearly described and understood by key stakeholders (i.e. what works and what to avoid)
- On-going monitoring and review systems in place for those with complex support needs, linking in with the service user's local CCG
- Having someone to talk to at short notice
- Problem solving learning to see where things go wrong and how they could be put right.
- Having sufficient capacity for responding with extra professional support around the person in situ
- Contingency options of going somewhere else for a period of time as a crisis respite or refuge breaks (such as social crisis and planned respite/breaks service)
- Access to crisis Mental Health and Learning Disability home treatment and admission to in-patient facility options through stepped care pathways

For any concerns outside of office hours, service users and carers will be encouraged to seek appropriate support elsewhere e.g. call the out of hours GP service or present to A&E; or contact the London Borough of Hackney Out of Hours Duty Team. The Service needs to ensure such information is available and shared appropriately in a clear and in an accessible format.

It is expected that there will be clarity around service pathways by the end of year one.

Key Partnerships Include…
Primary Health Services; Supported Employment Services; Client Affairs Team; Social Care Services; Community Volunteer Services; Support Providers; Public Health

12. Complex and Longer-Term Specialist Cases

The Service will provide assessment and intervention for clients where the impact of their learning disability adversely affects their capacity to fulfil their potential in terms of independence, inclusion, making choices and living healthy lifestyles.

The Service is required to work with a range of caseloads and presentations such as clients with complex, severe and enduring problems, disorders related to learning disabilities, people with additional disabilities, severe challenging behaviours, mental health difficulties, dementia, dysphagia, long-term conditions, epilepsy, autism, personality disorder and those who are part of the criminal justice system, and/or who have been victims of abuse or are otherwise at risk.

The Service must be able to support those who, because of on-going complex support needs will remain in contact with the service for long term interventions e.g. many of the Transforming Care cohort. This will often include those with reduced mental capacity who meet the criteria under the Mental Capacity Act, requiring Best Interest Assessments and Deprivation of Liberties Safeguards (DoLS) input.

The Service will offer an individualised approach and will design support to meet individual needs. This will include determining if /what support and placements are appropriate to individual need.

This Service shall provide specialist care/support coordination, which may require monitoring for periods of several years or even life-long in some cases; with some individuals requiring options to step-up and step-down support. Service users receiving support will have and participate in regular, individual meaningful reviews of their support (as per Care Act or Continuing Health Care guidance). All reviews should include a review of health and social care needs.

The Service must deliver continuity of care for vulnerable people with complex needs requiring intensive intervention and/or long-term support, including an identified ‘named worker’ for these service users. It will work in partnership with the service user, their carers, networks and other services to ensure needs of such service users are effectively met.

It is expected that the Service will increase provision of communication and hospital passports (a description of how best to communicate with the individual service user) for all service users with a significant or complex communication difficulty.

The Service should provide consultation, advice, assessment and intervention in a person-centred way, including:

- relevant accessible information for service users and carers.
- specialist information, consultation, advice and support to relatives, carers and support workers.
- effective communication of confidential and specialist condition-related and personal information
- expert specialist advice, guidance, consultation and support to other professionals in a wide range of settings
- broader theoretical knowledge and specialist clinical skills to develop or support the ability of others

- Specialist and complex assessments of people with learning disabilities and summary formulations/ diagnosis including a good understanding of the person's history and narrative
- complex risk assessment and risk management programmes
- skilled evaluations and decisions about treatment options
- care/treatment plans for the treatment/management of a person's problems
- a range of complex highly specialist clinical interventions, employing methods based on proven efficacy and best practice
- physical health support and advice
- care coordination where appropriate, including initiating, planning and review of care plans e.g. CPA/CHC/Care Act
- outcome focused health and social care reviews that involve the appropriate people involved in that service users' life and the delivery of support e.g. family, Client Affairs representatives; advocacy
- access to bed-based services only where health input is highly intensive or unpredictable
- support with those admitted to hospital to ensure appropriate assessment and treatment
- an eclectic range of interventions beginning from an assumption that input locally is the first option to be explored.
- Commitment to using the 'least restrictive option'.
- Support with meaningful end of life care.

When working with people who have profound and multiple learning disabilities, the Service will adopt the Core and Essential Standards for Supporting People with Profound and Multiple Learning Disabilities (Doukas et al, 2017) as a tool to inform its service delivery and check the right measures are in place for the service user.

Where Continuing Health Care (CHC) funding responsibility has been agreed, or where joint funded complex care packages such as S117 aftercare arrangements apply, the Service is expected to:

- Facilitate specialist and community care assessment and care/treatment plans
- Support the completion of any specialist assessments
- Develop detailed individual client-level and service-level specifications
- Undertake a monitoring and service review/assurance function role, recording any key risks and issues.
- Follow protocol appropriately e.g. the CHC Protocol.

Key Partnerships Include…
Health Services; CSU/CCG; Advocacy; Client Affairs Team; Brokerage; Social Care Services; Community Volunteer Services; Support Providers

PEOPLE WITH LEARNING DISABILITIES WHO ALSO HAVE A MENTAL HEALTH DIAGNOSIS OR BEHAVIOUR THAT CHALLENGES

The Service will provide specialist service for adults who present with a learning disability with additional history of severe and enduring mental illness; emotional problems, long standing emotional distress, vulnerability and abuse. The role of specialist or Approved Mental Health Practitioners (AMHPs)/ social supervisors and Psychiatrists in the Service will be crucial in the support for these individuals and where possible, safely maintaining people in a community setting.

The Service will offer timely, specialist support and consultancy to learning disabled users and their carers for a range of complex and severe challenging behaviours, dementia and serious offending behaviour. In addition to involvement in the promotion of good mental health, the Service will play a central role in hospital discharge planning and the Care Programme Approach and Transforming Care pathways. The provision of specialist education, consultation and advice are key aspects of such work.

The Service will ensure people with learning disabilities with behaviour that challenges are able to receive urgent mental health care when required, leading to a specialist mental health assessment where necessary within 24 hours or the next working day.

The Service will follow the guidance at laid out in *Positive and Proactive Care* guidance (DOH, April 2014), on reducing the use of restrictive physical interventions. This will ensure the Service uses day-to-day practices that:

- Are based upon Positive Behaviour Support
- Ensure that services provide strong leadership, assurance, accountability
- Are transparent about both the care they provide and when restrictive practices are used
- Provide effective monitoring and oversight through CQC and local professional/service inspections
- Support effective medication management (e.g. participation in the STOMP Project and advising on appropriate use of antipsychotic medications and dosage).

It is expected that most people's health needs will be able to be met in community settings and only a small number of people should need to access specialist in-patient beds appropriately. It is expected that the Service will work in partnership with Mental Health Trusts.

When a service user needs admission to in-patient services for more intensive help than can be provided in the community, the Service should offer time-limited active assessment, care and treatment, and links in with other services to enable a return to the community as soon as possible. For those with mental health or forensic presentations, support should be formalised with specialist mental health services and planning around rehabilitation in place.

While admitted to crisis centres, the Service should support people with learning disabilities and their carers/support staff to:

- be clear how long they will stay in an in-patient unit or emergency respite resource
- understand what their rights are
- feel supported and safe, ideally with those who are familiar to them.
- be offered assessment and treatment and effective care co-ordination
- know who is in charge to make sure things get done
- be helped to return home as soon as possible.

Where people are placed away from their own locality, it is important that the Service regularly reviews placements in order to ensure it is still safe, effective and appropriately meets the service user's needs.

The Service is expected to work proactively in a multidisciplinary way with a forensic cohort e.g. those who are released from secure settings but also those who are at risk of offending, to promote positive behaviours and reduce the risks of re-offending. Further work will be developed around this cohort and pathway within the first year of the contract.

13. Transforming Care Programme

As part of the National Transforming Care Programme (TCP) each CCG is required to keep "a dynamic risk register" of those who are either in an Assessment and Treatment Unit or secure setting who have a diagnosis of LD and/or autism who present with deteriorating mental health or behaviour which is challenging. This register will be reviewed regularly and the Service is expected to collaborate with this.

A Care and Treatment Review (CTR) is triggered by any staff and is organised by the commissioner; if they have been admitted or are considered to be at risk of admission. The local policy will reflect the national criteria for consideration of deteriorating behaviour, but often clinical judgement is paramount in these cases.

The Service will work with the LD commissioner to identify service users aged 14+ years, with LD and autism/challenging behaviours which are at risk of admission to an Acute Treatment Unit or acute mental health ward. These details would be held on the admission avoidance/at risk register and risk rated as per local protocol. Staff in the Service will be aware of and follow the protocol to identify deterioration and advise accordingly.

The Service is required to support the Joint Commissioner for Learning Disabilities, the CCG and report to NHS England to meet standards, targets and areas for improvement relating to the TCP including:

- Care and Treatment Reviews (CTRs) for all patients who did not have a confirmed discharge date and discharge plan in place;
- The fixed-term recruitment of strategic case managers by NHS England, to liaise with and monitor CCG planning and progress; and
- The requirement for CCG Transforming Care leads to submit fortnightly reports detailing the current status and discharge planning for their patients.
- Medicines and prescribing for people with LD
- Support to maintain a local dynamic risk register.

It is expected that staff in the Service will be aware who is on the register and if there are changes or new additions they discuss with the responsible commissioner, document and participate in the CTR and subsequent action planning in a professional and timely manner.

Staff from the Service are required to attend the monthly admission avoidance meetings to discuss service users at the request of the LD commissioner and develop action plans.

POSITIVE BEHAVIOUR SUPPORT

Positive Behaviour Support (PBS) is a multi-layered framework for improving the quality of life of people with learning disabilities and/or autism whose behaviour challenges services. The focus is upon the person and others with whom the person has a close and significant relationship.

The Service shall adhere to the following standards developed in relation to Positive Behavioural Support (PBS):

1. The service evidences how the PBS values base informs their practice
2. The service evidences that they know each person they support and can match that support with goals that are important to the person and their families
3. The service evidences that each person is supported to communicate effectively
4. The service evidences that each person is supported to make choices, and participate in meaningful activity
5. The service evidences that the physical, emotional and psychological health and wellbeing of each person is supported and promoted
6. The service evidences that they actively seek the involvement of family, friends and wider community for each person they support
7. The service evidences that people feel safe and secure, valued and respected, in predictable and stable environments

The Service will co-develop positive behaviour support plans with the individual, families and the support partners where appropriate. This will identify triggers and actions required to enable and manage risks and be followed by support staff working with the individual.

The Service will be compliant with the PBS Competency Framework - http://pbsacademy.org.uk/wp-content/uploads/2016/11/Positive-Behavioural-Support-Competence-Framework-May-2015.pdf

Key Partnerships Include…
Mental Health Services (including acute and rehabilitation services), Court Liaison and Diversion schemes, Social Care providers; Specialist Forensic Services, Probation, Ministry of Justice representatives; support networks

14. Safeguarding

Outcomes:

People feel safe

People are free from physical and emotional abuse, harassment, neglect and self-harm

Safeguarding is everybody's responsibility. All staff will undertake mandatory safeguarding training relevant to their role and duties. Any concern about a child or adult at risk must be escalated and discussed as soon as practicable with a senior member of the team.

The Service must reflect best practice and responsibility, protecting the individual with due regard to vulnerability and safety, ensuring that safeguarding practice is robust and that the safeguards e.g. afforded by advocacy and the Mental Capacity Act, are fully met.

All practitioners in the Service should take the lead in managing positive interventions that prevent deterioration in health and wellbeing; safeguard people at risk of abuse or neglect, or who are subject to discrimination, and to take necessary action where someone poses a risk to themselves, their children or other people.

The Service must take an outcomes-focused, person-centred approach to safeguarding practice, recognising that people are experts in their own lives and working alongside them to identify person centred solutions to reduce risk and harm. In situations where there is abuse or neglect or clear risk of those, social workers must work in a way that enhances involvement, choice and control as part of improving quality of life, wellbeing and safety.

The Service shall:

- Comply with and support the delivery of Pan London Adults Safeguarding Procedures, timeframes and operate under the Council's multi-agency protocol.
- Deliver the requirements of the Safeguarding Adults Board, including ensuring appropriate representation.
- Support the Local Authority in delivering the requirements of the annual Safeguarding Adults Return.
- Deliver the requirements of the Mental Capacity Act, Care Act and the associated code of practice, including DOLS.
- Maintain an effective interface between Adults and Children's services, by supporting the delivery of the SEN reforms which extend the responsibilities of transitions to the age of 25.
- Ensure the delivery of quality outcome measures.
- Enable the participation of service users, family members, carers and advocates in safeguarding processes.
- Work in partnership with other organisations (e.g. those providing care and support, and host boroughs) as part of safeguarding approaches.
- Ensure the effective budget management and note that local authority resources might not be fixed due to austerity.
- Inform the CCG of any issues relating to placements and support packages for health care funded clients

Key Partnerships Include…
The Police, Safeguarding Adults Services; Advocacy; Judicial representatives; Children & Families Services

15. Continuing Health Care (CHC)

The National Framework for NHS Continuing Healthcare and funded Nursing Care (DH 2007, revised 2009; 2012; 2018) sets out the principles and processes for the implementation of NHS Continuing Healthcare & NHS funded-nursing care and it provides national tools to be used in assessment applications and for Fast Track cases. The Service is expected to adhere to these processes and principles.

PRINCIPLES

1) People will have fair and equitable access to NHS funded continuing healthcare and have a positive experience of the process.
2) Decisions about eligibility will be transparent for people, their carer/family and partner agencies.
3) Informed consent will be obtained and if the person lacks capacity a 'best interests' decision will be taken on their behalf. No third party can give or refuse consent on behalf of a person who lacks capacity, unless they have valid and applicable Lasting Power of Attorney for Welfare or have been appointed as a Deputy by the Court of Protection for Welfare only.
4) Health and social care professionals will work in partnership with person and their carer/family throughout the process and adopt a person-centred approach.
5) The person and their carer/family will be provided with information (including easy read) to enable them to participate fully in the process; reasonable adjustments will be made as appropriate.
6) Advocacy support will be offered when appropriate to help people through the process.
7) At least two professionals from different disciplines will complete the Decision Support Tool.
8) Assessments and eligibility decisions should be undertaken within 28 days of the completion of the CHC Checklist and every effort will be made to ensure that people receive the care they require in the appropriate setting without unreasonable delays.
9) Personal Health Budgets will be the default delivery model for all NHS Continuing Healthcare funded home care.
10) The outcome is clearly communicated in an accessible format and in writing for the individual.

The Case Coordination role can be held by an individual from differing professional backgrounds and a multi-disciplinary team used to ensure:

- A fully evidenced decision
- A holistic assessment which can then lead to a clearly defined package of care
- Joined up working which reduces disputes between statutory organisations.

All practitioners in the Service should have good knowledge and understanding of the CHC Framework, appropriate CHC Tools, local processes and the individual. The Service will ensure proportionate completion of the NHS Continuing Healthcare Checklist, ensuring that resources are directed towards people who are most likely to be eligible for CHC. The Service should ensure accurate scoring of CHC checklists.

If the checklist indicates a need to carry out a full assessment of eligibility for NHS continuing healthcare, the Service will ensure this assessment is followed up appropriately by completion

of a Decision Support Tool and a decision made within 28 days of City and Hackney CCG receiving the Checklist.

Relevant documentation e.g. completed checklists or Fast Track Tools, should be forwarded to CHCCG by the Service for monitoring purposes and future reference.

Placement details including provider, support package and a breakdown of costs together with panel date must be forwarded to the CHC co-ordinator for the CCG.

A local CHC Protocol is currently being developed and, once agreed, the Service is expected to follow this.

NHS FUNDED NURSING CARE (FNC) -
In some cases, the need for care from a registered nurse may need to be determined following a nursing needs assessment by the Service. This assessment will specify the day-to-day support needs of the person and the outcome will be used to assess whether they are eligible for FNC.

The Service is expected to follow The Department of Health's Guidance around FNC and liaise with Brokerage and the CCG as appropriate e.g. completion and submission of relevant form to the CCG to support eligibility, placement and payment arrangements.

16. Service User Involvement

Outcomes:

People with learning disabilities and their carers are satisfied with the Service.

Carers report that they have been included or consulted in discussion about the person they care for.

The Service will ensure and demonstrate that service delivery is informed by service users and carers at every level e.g. at an individual planning level and service direction at a strategic level. The Service will engage service users to place their voice, aspirations, and interests at the heart of service management and delivery. Engagement should be flexible and could include, but is not limited to, user reported outcomes; service user led meetings; 1:1 interviews; service user feedback, participation in staff recruitment.

17. Processes and Procedures

The Service will make sure there are effective and efficient processes and procedures in place to ensure it can deliver on the outcomes and objectives in a sustainable way, whilst ensuring there is a clear and smooth transition for the service user in their journey through the service.

Delivery shall be in line with health and social care legislative requirements and agreed Council and/or NHS protocols.

The Service must ensure information is in accessible formats for service users (e.g. Easy Read).

17.1 The Front Door:

The Service will be able to demonstrate clear means of access to the Service that is responsive in a timely manner. There will be clear lines of communication enable people with learning disabilities to get the right support at the right time.

In all instances consent should be sought from the service user and guided by the Mental Capacity Act, ideally at the time of the referral or soon after for their engagement with the Service

The Service will create an assessment process which can:

- Identify need and outcomes for individuals referred (including for those people deemed to have ineligible needs).
- Facilitate access to services where necessary
- Act as a single assessment so the individual does not have to keep repeating their story
- Be shared with the individual

Where all or some of a person's needs do not meet the eligibility criteria, or where an individual has no eligible needs, they will nevertheless be offered advice and information about:

(a) what can be done to meet or reduce the needs;
(b) signposting to other appropriate services where needed.

The Service is expected to work within the following response times:

Acknowledgement of referral	5 working days
Acknowledgement/Response to query	5 working days
New adult referrals receive initial 'joint multidisciplinary comprehensive single assessment'	6 weeks of referral
Allocation of a transition to adulthood social worker for transition to adulthood cases	By the individual's age of 16
Completed assessments and decisions regarding eligibility to adults' services for transition to adulthood cases referred to service	By the individual's age of 17
CHC Assessment and eligibility decision following completion of the CHC Checklist	28 days

Carers will be offered a Carer Assessment if needs are identified as part of the assessment process and as per local guidelines.

17.2 Input and Support

The Service will develop a process and tools to ensure that service users and their carers are at the heart of assessment, treatment and support planning and review. Practitioners must be able to develop personalised assessment and care plans that enable the individual to determine and achieve the outcomes they want for themselves.

Support and treatment plans need to demonstrate involvement of service users and where appropriate their carers and include clear, agreed outcomes and goals for that service user.
An accessible copy of such plans should be given to the service user in line with the Accessible Information Standard ('DCB1605 Accessible Information').

Individual support plans and reviews should be shared with the support provider in a timely manner to enable clarity around provision.

The roles and needs of informal or family carers should be recognised and holistic, systemic approaches used to support individuals and carers.

It is important that the Service develops knowledge and good partnerships with community resources to work effectively with individuals.

Input and support should be delivered by the Service in a coordinated, multidisciplinary and joined up way.

Support should be consistent with clear points of contact such as a named worker (SCIE, 2018 https://www.scie.org.uk/social-work/named-social-worker).

Effective processes should be in place with appropriate governance to ensure individual need and packages are monitored and clear decision making recorded. This should include reporting on financial implications.

17.3 Leaving the Service

The Service should ensure positive move-on for service users is at the heart of its work, supporting people with learning disabilities to achieve their goals, where possible their full potential and reduce the need for a specialist service.

It is important that service users and their carers have clarity around signposting if needed; methods and resources to sustain their independence from the Service and a means of contacting the Service should needs change; this could include an information pack that identifies what goals have been achieved and contacts where the service user can go for help if needed.

Criteria for closures to the ILDS:

1. Intervention not accepted by service user or carers*
2. Service user has moved independently out of borough
3. Death of a service user
4. Other reasons following discussion by the multidisciplinary team.

**Caution should be taken to ensure that carer is acting in best interests of the service user and service user mental capacity considered.*

A closure/discharge report will be written by the designated named worker or professional involved. This will include recommendations for further support if applicable and with signposting and advice for future intervention and details for making a re-referral. This will be sent to the client and a copy sent to the GP.

CLIENTS MOVING OUT OF THE BOROUGH

When clients are moved out of Hackney with a service commissioned by LBH, Adult Social Care will remain responsible for care. Transfer of health care will be to another Community Learning Disabilities Service and primary care services within the client's new area within a month of the client's move.

There will be a transfer period of a maximum of six months following the move whereby health professionals from the Service will continue to offer advice and support. Once the transfer process is complete the client will be closed to the health professionals of the Service, though advice and support can be provided by health care professionals to social work colleagues.

For clients who move voluntarily out of borough, they will become an 'Ordinary Resident' of the area in which they move to. The Service will no longer commission services but will liaise and refer to local services where necessary including local Learning Disabilities Services and provide a handover.

An Out of Borough Protocol will be developed to support with procedures when service users move out of Borough and the Service is expected to adhere to this.

18. Staffing

The Service is expected to ensure there is suitable staffing in place to ensure safe and effective delivery of the Service.

The Service will ensure appropriate guidance is followed with regards to the specialist nature of service provision by the professionals in the Service (e.g. as in Safe, Sustainable Protective Staffing – An improvement for learning disabilities services; National Quality Board, 2018).

The Service is responsible for ensuring staff are appropriately qualified, meet relevant professional requirements, undertaking relevant checks and that staff are suitably trained to deliver the service.

All new staff and students to the team, including agency and bank staff, will receive a local induction.

Staff shall demonstrate ability to:

- Provide person-centred bespoke support
- Ensure well-being and promote human rights
- Build community capacity by promoting independence
- Reduce unnecessary hospital admissions
- Ensure consistency of care
- Use of best and evidenced based practice
- Knowledge of innovative and emerging practice in the field of learning disabilities.
- Reflective practice and engagement in continuous professional development
- Fulfil their statutory responsibilities
- Provide a holistic approach to assessing need and providing support.
- A commitment to multidisciplinary, interagency and partnership working.
- Deliver an outcome focused and enabling approaches.
- Deliver an ethical and equitable service.
- Effective communication skills including those with special communication needs. This includes adherence to the five good communication standards:

1. There is a detailed description of how best to communicate with individuals.
2. Demonstrate how they support individuals with communication needs to be involved with decisions about their care and their services.
3. Staff value and use competently the best approaches to communication with each individual they support.
4. Create opportunities, relationships and environments that make individuals want to communicate.
5. Individuals are supported to understand and express their needs in relation to their health and wellbeing.

(Royal College of Speech and Language Therapists, 2013)
https://www.rcslt.org/news/docs/good_comm_standards

All staff must have supervision, every four to six weeks in line with professional and local standards; this must be documented. Informal supervision should be undertaken as and when required.

Staff who hold professional registration working within the Service must adhere to relevant Professional Standards & Codes of Ethics and Continuing Professional Development requirements.

Each discipline in the Service will be responsible for maintaining up to date practice within their specialism and in the context of learning disabilities specialist support.

Practitioners in the Service will have, or have a commitment to develop a core set of skills, such as:

- Assessment of learning disability need and delivery of specific interventions.
- Knowledge and understanding of the Mental Capacity Act (MCA) and Code of Practice and be able to apply these in practice e.g. mental capacity assessment.
- Communication Skills and Strategies including those who have significant communication difficulties.
- Dysphagia awareness
- Health improvement and enablement approaches
- Care Co-ordination
- Advocacy
- Clinical Leadership
- Person Centred Approaches
- Ability to plan, grade and deliver appropriate service user goals and outcomes.
- Ability to be reflective and a commitment to professional development.
- Proactively working and engaging with others
- Awareness of Mental Health Legislation and Basic Mental Health Screening
- Awareness of Clinical Governance and ability to undertake audit
- Autism Awareness
- Epilepsy awareness
- Risk assessment
- Ability to work autonomously within community and other settings (lone working).
- Manual Handling

Practitioners need to be able to work effectively with individuals and their families using professional approaches, good interpersonal skills and emotional intelligence, developing relationships based on openness, transparency and empathy.

Staff must work effectively and confidently in partnership with professionals in inter-agency, multi-disciplinary and inter-professional groups particularly at the interface between health, children and adult social care and the third sector.

Professionals in the Service should play an active role in strategic planning, care package oversight, supporting wider commissioning.

They should contribute to developing awareness of personalisation and outcome-based approaches to improving people's lives.

LEADERSHIP

There will be clear lines of responsibility and accountability with effective clinical, management and leadership structures in place.

All staff should demonstrate a degree of leadership throughout the Service.

19. QUALITY

The Service will ensure it delivers a high quality, seamless service and will be able to demonstrate this.

It will maintain appropriate performance information to enable the Local Authority, CCG and ELFT to meet statutory reporting requirements, including:

- The statutory annual return, financial return; returns for the Service.
- Any additional Local Authority requested performance measures as agreed on a periodic basis.
- The ASCOF requirements as listed in Appendix

KEY PERFORMANCE INDICATORS (KPIS)

The Service is expected to demonstrate how it is delivering the four local outcomes see Appendix 2.

A small number key performance indicators (KPIs) have been selected with a focus on outcomes that are detailed in the service specification. These are indicators only and the focus should remain on outcomes. Our contract management and monitoring approach will require that qualitative information is used to supplement and illustrate the quantitative returns against these KPIs. Commissioners will agree the nature of qualitative information with the provider but it is likely to take the form of simple case studies.

Commissioners will work with the provider to identify priority areas each year where appropriate. For example, the selection of which mainstream services to work with for KPI2.

KPIs will be reported on as part of contract monitoring of ILDS, undertaken quarterly and shared with the Commissioning Section 75 Board. Any targets not achieved would be subject to Commissioner review and service improvement planning. Further details on these KPIs can be found in the Appendix.

KPI		Target
1	80% service users achieve their goals following intervention from ILDS.	80%
2	Advice, guidance and or training delivered by ILDS to mainstream services makes a demonstrable, positive difference to accessibility for people with learning disabilities.	4 per year
3	80% of ILDS service users live in settled accommodation within the first three years of the contract.	80%
4	Having input from ILDS has made a positive difference to service users' lives.	85%
5	Safety - Service users are identified in a timely way of being at risk and risk assessed appropriately. All service users who are identified as being at high risk have a risk management plan and the service can demonstrate proactive steps are taken to mitigate risks.	100% of those in High Risk

For activity data for the service please see Appendix 3

The Service will ensure there is a suitable framework and mechanisms in place to assure appropriate care governance. This will include assurances to external inspectors such as the Care Quality Commission.

CONTINUOUS SERVICE IMPROVEMENT

The Service needs to continually develop its capacity to respond to local needs and adapt the skills base to match changing demand. It should play a significant leadership role in coordinating and demonstrating action in line with the national and local joint Health and Social Care learning disabilities standards and frameworks.

The Service will proactively engage in quality improvement of the Service. This will include but is not limited to regular audit (such as clinical audits); seeking and responding to feedback from service users, carers, complaints and compliments; keeping up to date with relevant legislation.

QUALITY ASSURANCE AND MONITORING REQUIREMENTS

The Provider must have a quality management system in place to ensure internal control of quality and consistency of practice and be committed to a process of continuous service improvement. To demonstrate continuous improvement, the Provider will be required to:

- Submit activity and performance data to the Authority as detailed in this specification;
- Develop and agree a service improvement plan with the commissioning authority to address any underperformance identified as part of the contract monitoring and review processes;
- Ensure that the views of Service Users and families/carers are actively sought and used to continuously improve the quality of support provided and demonstrate how service users who have received support are used to influence service improvements;
- Cooperate in the provider concerns process.

Key performance indicators, performance indicators, and outcomes will be reviewed on a quarterly basis throughout the life of the contract.

The activity and performance data should be submitted to the commissioning authority via a Service workbook within two weeks of the quarter end. The format of the workbook will be finalised during the first six months of the service starting and will link in with the commissioning quality assurance framework. The Council may spot check and audit Service documents and provision to ensure contract compliance and quality assure practice throughout the life of the contract.

Throughout the lifetime of the contract, the Service will hold quarterly quality assurance and monitoring meetings with key stakeholders including but not limited to the Council's Commissioning Team. On an annual basis, the Service will be subject to quality, function, and performance review.

20. Information Governance and Confidentiality

The Service is expected to adhere to the Trust's and Hackney Council's policies and procedures in relation to record keeping, patient confidentiality, with due regard to the Mental Capacity Act 2005 and Pan London Safeguarding Adults procedures, the Care Act 2014. All contacts with service users will be recorded on the appropriate database. Correspondence with other health professionals will follow appropriate guidance e.g. ensuring GPs are kept informed with appropriate documentation.

Permission to Use and Share Information forms will be completed with all service users and their families/carers and copied to the relevant database/s. The Service will respect service users' wishes on confidentiality as far as is possible and adopt the approach of nothing about us without us, i.e. ensuring users have copies of relevant correspondence about them.

There are some exceptions to the Duty of Confidentiality where permission is not required:

- Where disclosure is required by law (legislation or court order).

- Where the disclosure is in the public interest e.g. to protect a member of the public from harm (including carers and family members), or to protect the patient.
- Where there is an 'overriding concern' about the patient's safety or the safety of others
- If the service user is deemed not to have capacity under the Mental Capacity Act, 2005 information may be passed to their carer if it is in the patient's best interest.
- Where possible this will be communicated to the patient and the decision recorded.

Service Users wishing to access their records will need to follow the steps set out in the Trust's Access to Records policy or the Council's Records Management Policy.

All staff are expected to complete mandatory training in Information Governance.

All staff must follow the Information Governance and IMT Security Policy where there has been a misuse of personal information in relation to the person's health records. Where a breach has occurred in relation to adult social care or health records, the relevant process should be followed. All Trust guidance regarding Duty of Candour must be followed.

CONFIDENTIALITY REVIEW

The Service must adhere to the Council's Confidentiality Policy. This sets out areas where information will be shared and under what circumstances and serves as a record of their consent within these areas. In other cases, the residents' consent must be obtained as the need arises. This includes passing information to other agencies.

The Confidentiality Policy must set out the Council's requirements concerning its access to the Provider's records relating to service users. The Provider must ensure that everyone engaged in the Service with access to personal information understands their responsibilities and can demonstrate evidence of compliance with their procedures. This includes employees, volunteers, self-employed workers, consultants or contractors.

The procedure must comply with the Data Protection Act 2018 and any contractual requirements. It should also cover accuracy and consistency of record keeping, security of data, information to service users, and consent for disclosure requirements and identify responsible persons. Contracts of employment, volunteering agreements, contracts with consultants and others should include a clause making explicit the person's responsibilities for confidentiality and data protection. The policy should also cover actions to be taken if a staff member breaches confidentiality.

The Provider Confidentiality Policy must be aligned to the principles laid out in the 2013 Caldicott review of information sharing in the health and social care system:

- Justify the purpose(s)
- Don't use personal confidential data unless it is absolutely necessary
- Use the minimum necessary personal confidential data
- Access to personal confidential data should be on a strict need-to-know basis
- Everyone with access to personal confidential data should be aware of their responsibilities
- Comply with the law
- The duty to share information can be as important as the duty to protect [Service User] confidentiality

21. Management of Case Files

All client and carer information will be stored in line with the Trust's and Council's policies regarding Information Governance. Staff should have access to both the ELFT and LBH intranets to view the policies.

22. IT Requirements

The service will ensure that all staff have and comply with the following:

- Providing and maintaining IT equipment so that is fit for purpose.
- Use all of the Council's and the Trust's management information systems and processes or any system that might be developed in the future.
- Compliance with LBH and Trust recording protocols and reporting requirements.

23. Incident Management

All incidents are dealt with the Council's Incident Reporting procedure. All staff are expected to report incidents and near misses via LBH's reporting procedure. All health-related incidents will need to be reported via the Trust's Datix system an in line with Trust protocol.

All incidents or near misses should be discussed with a manager or senior member of the staff. The member of staff reporting the incident must ensure the information in the incident report is factual, accurate, comprehensive and timely.

The guidelines on timeframes for reporting incidents and near misses is as soon as practicable (immediate remedial action to deal with the incident is likely to take priority over completion of an incident report) and always within 24 hours of the incident. Serious incidents should be reported within two hours.

Learning from all incidents and near misses will be reviewed as part of lessons learnt discussions within clinical governance meetings and team meetings.

24. Health and Safety

The nominated Risk Officer will lead on all aspects of health and safety under the supervision of the appropriate manager. This includes the annual health and safety audit and following up any outstanding actions. The manager and Risk Officer will also lead on building issues and escalate any issues to Estates and Facilities.

The Service staff will adhere to Hackney's Lone Worker Policy and Lone Working Procedures can be found on the staff intranet.

25. Risk Management

The service will manage clinical risk in line with the Trust's Clinical Risk Assessment and Management policy including the completion of a risk assessment tool for all clients referred for

interventions. Specialist risk assessment tools and risk screening tools should also be used where applicable.

Staff will update risk assessments when required i.e. any change in presentation, and as part of a scheduled review. Risks are to be discussed with the team manager and lead clinician where appropriate. Risk assessment and management will be discussed within the MDT meetings, peer reviews and during supervision.

Staff must update the risk status of patients on the note's system/s, this includes adherence to the TCP protocol.

26. Equality and diversity

Hackney is a culturally diverse borough and the Service must be culturally sensitive. It must have an Equality and Diversity Policy that can be provided on request. The policy must cover the ways in which the Service will promote equality of opportunity and prevent discrimination in relation to those protected characteristics outlined in the Equality Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Information on these must be gathered as a matter of course so they can be reported on.

The Service will ensure, at a minimum, the following good practice is followed:

- Recruitment, Selection, and Retention policies are appropriately developed to ensure that the workforce is diverse and the workplace is inclusive;
- All staff will be required to attend Equality and Diversity training to equip them with the skills and knowledge to carry out their tasks in a culturally sensitive, non-discriminatory manner;
- Anti-discriminatory, pro-equality, and confidentiality messages are prominently displayed with clear actions for Service Users, staff and others if they feel these have been breached;
- Complaints are monitored and corrective action is taken as necessary;
- All residents who receive support from the Service have access to the appropriate communication resources for their needs, including translation, interpreting services, sign language and braille;
- The Service User population will be monitored by protected characteristics to identify anomalies against the general population and gaps in provision.

The Service will make available to service users and/or families/carers who use the Service a copy of its Equality and Diversity Policy at commencement of the service. Likewise, a copy will be made available for staff at commencement of employment.

The Service must align to LB Hackney's Equal Opportunities and Cohesion Policy Statement and Equal Opportunities Policy. https://www.hackney.gov.uk/media/2859/Equality-and-cohesion-policy/pdf/Equality-and-Cohesion-Policy

27. Location of the Service

The service shall be based at:

Hackney Service Centre

1 Hillman Street

London

E8 1DY

However, the Service will have some clinical services at St Leonards, Nuttall St, N1 5LZ.

It will also ensure service delivery in a range of settings such as service users' homes and other community settings.

28. Applicable Service Standards

The Service is expected to be compliant with the following legislation and work towards best practice as identified in the listed applicable service standards.

The Care Act (2014) Support delivery of the statutory requirements of the Care Act: - Meet the new statutory obligations around Carers, by ensuring their involvement in the development and delivery of services, and conducting Carers assessments; - Delivery of a whole family approach to transitions; - Delivery of the Think Local Act Personal agenda - Delivery of the Personalisation agenda. Mental Capacity Act (MCA, 2005) and Code of Practice The Autism Act	● Health Equalities Framework (HEF) ● Building the Right Support Service Model 2015 (Transforming Care) ● DH (July 2013) Six Lives: Progress Report on Health for People with Learning Disabilities. London, DH ● DH (December 2012) Winterbourne View Review Concordat: Programme of Action ● Hoghton, M., Turner, S and Hall, I (October 2012) Improving the Health and Wellbeing of People with Learning Disabilities. An Evidence Based Commissioning Guide for Clinical Commissioning Groups (CCGs) Learning Disabilities Observatory, RCGP, Royal College of Psychiatrists ● Learning Disability Services Inspection programme: National Overview (June, 2012). CQC ● Emerson, E et al (2012) Health Inequalities & People with Learning Disabilities in the UK: 2012 ● Turner, S and Robinson, C (2011) Health Inequalities and People with Learning Disabilities in the UK: 2011. Implications and actions for commissioners. Evidence into

The Children and Families Act (2014) The NHS Long Term Plan (2019)	Practice Report No 1 (revised) Learning Disabilities Observatory ● Parliamentary and Health Service Ombudsman (March 2009) Six Lives ● DH (2009) Valuing People Now: a new three-year strategy for people with learning disabilities. London, DH ● DH (2009) Improving the health and wellbeing of people with learning disabilities. Best Practice Guidance. London, DH ● CQC (2009) Position statement and action plan for learning disability 2010-2015. CQC London ● Michael, J. (2008). Report of the Independent Inquiry into Access to Healthcare for People with Learning Disabilities. Healthcare for All ● Mencap (2007) Death by Indifference ● Mencap (2004) Treat me right! Best healthcare for people with a learning disability ● NPSA (2004) Understanding Patient Safety Issues for people with learning disabilities ● Department of Health (2001) Valuing People: A New Strategy for Learning Disability for the 21st Century. London, DH

The Service should ensure it maintains awareness of relevant future legislation, standards and plans that may affect people with learning disabilities so it can apply them appropriately.

APPENDIX I

Outcomes Framework for the Service

Domain 1. Preventing people from dying prematurely **NHS Outcomes Framework Domain 1 (Department of Health, 2013a), Public Health Outcomes Framework Domain 4 (Department of Health, 2014)**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Potential years of life lost from causes considered amenable to healthcare	Reduce premature mortality from the major causes of deaths in people with a learning disability	• Supporting primary, secondary and specialist health services with reasonable adjustments, accessible communication • Healthcare coordination for people with complex and multiple health needs • Facilitate access to mainstream healthcare services • Healthcare advocacy Reducing premature death in adults with a learning disability and serious mental illness/challenging behaviour • Facilitate access and joint working with generic, specialist and in-patient mental health services and out-of-hours/emergency mental health services so that skills, expertise and resources from these services could be utilised • Ensure and support monitoring of physical health of people with a learning disability and mental health/challenging behaviour • Where appropriate, joint working with community paediatric services
Domain 2. Enhancing quality of life for people with long-term needs and improving the wider determinants of health **NHS Outcomes Framework Domain 2 (Department of Health, 2013a), Public Health Outcomes Framework Domain 1(Department of Health, 2014)**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)

Quality of life related to health and social care for people with a learning disability and long-term conditions	Ensuring people feel supported to manage their condition Improving functional ability in people with a learning disability and long-term conditions Reducing time spent in hospital Enhancing quality of life for carers Enhancing quality of life for people with a learning disability and mental illness/ challenging behaviour Enhancing quality of life for people with a learning disability and dementia	• Person-centred planning of care and support needs • Ensure self-determination by providing opportunities to make choices • Enhancing independent living skills and activities of daily living • Enhance access to appropriate day and leisure opportunities • Health promotion • Hospital in reach services • Healthcare coordination for people with complex physical healthcare needs • Ensuring access to information and advice about support available, including respite care • Ensuring access to appropriate day opportunities • Managing people in the community or appropriate setting • Skilled long-term support to enable people to live as independently as possible in the community • Improved access to healthcare services • Ensuring people with dementia receive a timely diagnosis and the best available treatment and care with a clear pathway
	Ensuring care and support is more personalised so that support more closely matches the needs and wishes of the individual, putting people in control of their care and support. Asking people with	• Enabling people with learning disabilities have as much control over daily life as they'd like • Enabling people manage their own support as much as they

	learning disabilities about the extent to which they feel in control of their daily lives.	wish, so that they are in control of what, how and when support is delivered to match their needs. • Supporting adults aged over 18 / carers to receive self-directed support • Enabling adults and carers to receive direct payments
Proportion of adults with a primary support reason of learning disability support in paid employment	People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation. NB: it refers to the proportion of adults with a learning disability who are "known to the council" (those adults of working age with a primary support reason of learning disability support who received long term support during the year in the settings of residential, nursing and community but excluding prison), who are recorded as being in paid employment.	• Enabling and supporting people with a learning disability (of working age) into and sustaining paid employment through partnership working • Supporting workplace accessibility.
Proportion of adults with a primary support reason of learning disability support who live in their own home or with their family	'Living on their own or with their family' is intended to describe arrangements where the individual has security of tenure in their usual accommodation, for instance, because they own the residence or are part of a household whose head holds such security.	• Support people with a learning disability to live in stable and appropriate accommodation. Situations included within the scope of 'living on their own or with their family': - Owner occupier or shared ownership scheme; - Tenant (including local authority, arm's-length management organisation, registered social landlord, housing association); - Tenant – private landlord; - Settled mainstream housing with family/friends (including flat sharing); - Supported accommodation/ supported lodgings/supported group home (i.e. accommodation supported by staff or resident caretaker); - Shared Lives Scheme (formally known as Adult Placement Scheme);

		- Approved premises for offenders released from prison or under probation supervision (e.g. probation hostel); - Sheltered housing/extra care housing/other sheltered housing; and, - Mobile accommodation for Gypsy/Roma and Traveller communities.
Proportion of people who use services and carers, who reported that they had as much social contact as they would like.	Tackling loneliness and social isolation, supporting people to remain connected to their communities and to develop and maintain connections to their friends and family.	• Support with developing social networks and support. • Enabling people with a learning disability and their carers to participate in their community and community groups.
Domain 3. Helping people recover from episodes of ill health or injury, and delaying or reducing the need for care **Adult Social Care Outcomes Framework Domain 2 (Department of Health, 2013b), NHS Outcomes Framework Domain 3 (Department of Health, 2013a), Public Health Outcomes Framework Domain 2 (Department of Health, 2014).**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Delaying and reducing the need for care and support. Preventing admissions to hospital or permanent admissions to residential and nursing care homes because of placement breakdowns	Improving outcomes from planned and short term interventions	• Single care pathway, early diagnosis and intervention • Provision of effective short-term services that aim to enable people and promote their independence • Multidisciplinary team intervention • Use of care programme approach framework where appropriate • Facilitate discharge from the hospitals • Enhanced input to prevent placement breakdowns • Ensure access to primary care through health advocacy and liaison • Developing and delivering person centred outcomes.
	Helping people with a learning	• Healthcare coordination for

	disability recover their independence after illness or injury	people with complex physical healthcare issues • Supporting primary healthcare, rehabilitation and enablement services in providing care to people with a learning disability • Supporting social care providers in making reasonable adjustment to ensure proper community integration
	Reduce the delayed transfer of care from hospitals and reduce delays that are attributable to adult social care	• Effective multi-agency working and coordination to prevent delayed discharges • Active involvement and coordination in the discharge planning process between community and in-patient services • Working jointly with commissioners to ensure clear care pathways between mainstream and specialist services
Domain 4. Ensuring that people have a positive experience of care **Adult Social Care Outcomes Framework Domain 3 (Department of Health, 2013b), NHS Outcomes Framework Domain 4 (Department of Health, 2013a)**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Patient experience of care and support services including healthcare services	Patient experience of out-patient care	• Reasonable adjustments to improve access • Accessible communication • Training to improve staff competency in dealing with people with intellectual disability • Person-centred care
	Patient experience of hospital care and accident and emergency services	• Reasonable adjustments to improve access • Accessible communication • Provide training • Liaison with acute hospital services
	Improving access to primary care	• Supporting primary care with

		health action planning • Supporting primary care with reasonable adjustment, accessible communication, etc.
	Improving the experience of care at the end of life	• End-of-life care pathways for people with intellectual disability based on national guidelines
Proportion of carers who report that they have been included or consulted in discussion about the person they care for	Improving experience of healthcare for people with a learning disability and mental illness/challenging behaviour Improving experience of transition services Improving carers' experience	• Accessible communication • Waiting times • Person-centred care and support planning • To ensure good interface between generic mental health services and early intervention and emergency services • Joint and multiagency working. • Ensure multi-agency transition care pathways • Carer involvement and engagement in service delivery and service development • Appropriate use of advocacy
Proportion of people who use services and carers who find it easy to find information about support	People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.	• Supporting people with learning disabilities to find information and advice about support, services or benefits easily. • Supporting mainstream services to be accessible.
Domain 5. Safeguarding vulnerable adults and caring for people in a safe environment **Adult Social Care Outcomes Framework Domain 4 (Department of Health, 2013b), NHS Outcomes Framework Domain 5 (Department of Health, 2013a), Public Health Outcomes Framework Domain 3 (Department of Health, 2014).**		
Overarching measure and indicator	Outcome measure and improvement areas	Role of Integrated Learning Disability Service (ILDS)
Patient safety incidents including those involving severe harm or	Reducing the incidence of avoidable harm	• Ensure clinical and practice governance • Care programme approach processes where appropriate

death		• Quality assurances through regular audits and quality improvement projects • Incident reporting and learning from incidents
	Delivering safe care to people with a learning disability in acute settings	• Health advocacy on behalf of people with a learning disability • Training of acute healthcare staff in understanding needs of people with a learning disability • Close working and liaison with acute health services
People feel safe	People are free from physical and emotional abuse, harassment, neglect and self-harm	• Ensure effective safeguarding processes in the service • Incident reporting • Active joint working between the in-patient and community services to reduce length of stay in hospital • Working with commissioners to ensure person centred care in the in-patient and community services • Liaison and joint working with other agencies (e.g. police, domestic violence unit) and other boroughs.

APPENDIX II

STATUTORY MEASURES

Statutory returns from the service reported by Performance & Innovation team:

- Safeguarding adults return
- Guardianship
- Short and Long Term Services Return
- Survey of adult social care users
- Adult Carer Experience Survey
- Deprivation of Liberty Safeguards
- Adult Social Care Finance Return

The measures include:

- 1A - Social care-related quality of life
- 1B - Proportion of people who use services who have control over their daily life
- 1I (1) - Proportion of people who use services who reported that they had as much social contact as they would like
- 1J - Adjusted Social care-related quality of life – impact of Adult Social Care services
- 3A - Overall satisfaction of people who use services with their care and support
- 3D (1) - Proportion of people who use services who find it easy to find information about services
- 4A - Proportion of people who use services who feel safe
- 4B - Proportion of people who use services who say that those services have made them feel safe and secure
- 1D - Carer-reported quality of life
- 1I (2) - Proportion of carers who reported that they had as much social contact as they would like
- 3B - Overall satisfaction of carers with social services
- 3C - Proportion of carers who report that they have been included or consulted in discussion about the person they care for
- 3D (2) - Proportion of carers who find it easy to find information about services
- 1C (1A) - Proportion of adults receiving self-directed support
- 1C (1B) - Proportion of carers receiving self-directed support
- 1C (2A) - Proportion of adults receiving direct payments
- 1C (2B) - Proportion of carers receiving direct payments for support direct to carer
- 1E - Proportion of adults with learning disabilities in paid employment
- 1G - Proportion of adults with learning disabilities who live in their own home or with their family
- 2A (1) - 1415 - Long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population
- 2A (2) - 1415 - Long-term support needs of older adults (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

KEY PERFORMANCE INDICATORS

KPI		Target	Definition	Means of Measurement
1	80% service users achieve their goals following intervention from ILDS.	80%	Anyone who has received an intervention (e.g. treatment, support package) from the service. This includes those receiving social care support only, and those preparing for adulthood.	Examples include • Outcomes/goals identified and achieved in support and treatment plans. • Patient reported outcomes measures. • Quarterly reporting. This will start from 6 months of contract commencement.
2	Advice, guidance and or training delivered by ILDS to mainstream services makes a demonstrable, positive difference to accessibility for people with learning disabilities.	4 per year	Mainstream services (i.e. non LD specific services). This will include health services to support with addressing any local health inequalities for people with a learning disability.	These services make reasonable adjustments for people with a learning disability. For example, a library, a stop smoking clinic. Updated quarterly and more detail provided in an annual report.
3	80% of ILDS service users live in settled accommodation within the first three years of the contract.	80%	Settled accommodation is as defined by ASCOF. It also includes those preparing for adulthood	Proportion living in Residential or Nursing care compared with other settled accommodation such as supported accommodation, living with family, etc. Updated quarterly and more detail provided in an annual report.
4	Having input from ILDS has made a positive difference to service users' lives.	85%	The difference should be indicated by before and after measurement indicating that something good has happened to the service user.	Standardised/ non-standardised outcome measures. E.g. Health Equalities Framework; professional specific outcome measures; quality of life measures before and after. User experience. Good news stories. Notes' audit. Quarterly reporting
5	Safety - Service users are identified in a timely way of being at risk and risk	100% of those in High Risk	The Service will have a means of determining risk (e.g. type/ severity/	Examples of identification include the use of a risk register at point of assessment and review; CPA,

	assessed appropriately. All service users who are identified as being at high risk have a risk management plan and the service can demonstrate proactive steps are taken to mitigate risks.		likelihood).	following notification from others. Measurements for risk with appropriate procedures in place that are followed. Pan London Safeguarding procedures followed. Notes' audit. Incident reporting.

APPENDIX III

Suggested Reporting on Outcomes

INTEGRATED LEARNING DISABILITIES SERVICE CASE EXAMPLE TEMPLATE

This Case example should be completed and submitted to the Section 75 Board to demonstrate how the service has delivered on each of the key outcomes set in the service description. It should be no longer than two pages in length:

Case Identity Number:	
Client Cohort/Pathway:	
Outcome Achieved (Please Select): ▪ People with a learning disability are an active part of their community ▪ People with a learning disability are enabled to achieve independence where possible ▪ People with a learning disability have a place they call home ▪ People with a learning disability are able to access the health care they need.	
Brief Description of input:	
Evidence of multidisciplinary working:	
How you know the outcome was successfully achieved/ what difference did it make to the user?:	
Saving Made/Cost Avoidance (£):	
Practitioner/s completing the form:	
Date completed:	
Section 75 Board Submission (Select):	Q1 (April-June) Q2 (Jul-Sept)

	Q3 (Oct-Dec) Q4 (Jan-Mar)

APPENDIX IV

Activity Data

PI	Performance Description	Target by end of Yr. 1	Q1	Q2	Q3	Q4	Comment
1a	New adult referrals receive initial single assessment within 6 weeks of referral	95%					Quarterly
b	Number of discharges						Quarterly
c	Number of DNA						Quarterly
d	% of fully funded Continuing Health Care assessment in receipt of annual review and care plan	95%					Quarterly
e	% of new adult referrals have a completed assessment within- 12 weeks	95%					Reporting to start from Q3 in line with 12-week targets
2	% of people on Care Programme Approach (CPA) to have an up-to-date risk assessment (within 12 months)	95%					Reporting to start from Q3 in line with 12-week targets
3	% of clients have an up-to-date support plan (i.e. up-to-date within 12mths).	95%					Reporting to start for Q3 activity in line with care planning
4	% of people on the Transforming Care Risk Register and have the assessments in place (appropriate to the individual) as defined by Building the Right Support including Person Centred Care, Support and Risk Management Plan, Positive Behaviour Support Plan, Crisis/Contingency Plan and	95%					Reporting in place from Q1

	Communication Passport.						
5	Annual quality audit measures the quality of health action plans and NICE compliance of Care Plans. BASELINE.	Audit					Annual Audit (baseline to be agreed in Q1 YR1; Audit Q1 YR2
6	% of client on medication recommended by ILDS have up to date medication review (NICE compliant) within 12mths	95%					Reporting to start from Q1 Y1
7	% of case open to ILDS have a Health Action Plan (HAP) which includes if necessary, a needs assessment/care plan in relation to bodily awareness, pain response and communication support.	95%					Reporting to start from xx
11a	Number of Clients at age 14 and above with ILDS involvement measured by: ILDS attendance at annual reviews/ EHCP meeting's/ transition surgeries/ LAC reviews	number					Quarterly
b	% transition cases having an allocated ILDS transition social worker by age 16	%					
c	% all transition age cases referred to service at age 17 with completed ILDS assessments and decisions regarding eligibility to adults' services	%					
d	% complaints/ disputes/feedback from parents/ carers re: transition responded to within the Council's policy.	%					
12	% of those with antipsychotics medication review every 12 months.	95%					Year-end report (i.e. annually).
13	Number of clients in receipt of joint funding and associated costs	Number & Costs					Quarterly
14	Number of Patients on CTR	Number					Quarterly
15	Number of CTR patients with	Number					Quarterly

	discharge plan in place						
16	Number of GP Registers validated	Number					Quarterly
17	Average time patient waited for first clinical contact	Less than 6 weeks					Quarterly
18	Number of People supported to have a health check.	Number					Quarterly
19	% of assessments for CHC that meet the 28-day decision from the CCG	80%					Quarterly
20	Number of Safeguardings – open, closed, substantiated	Number					Quarterly
21	Number of Leder, Premature Deaths, Reviews undertaken annually	4/year					Quarterly

Title of report:	NE London Sustainability and Transformation Partnership Long Term Plan
Date of meeting:	10 October 2019
Lead Officer:	Jane Milligan, NE London Accountable Officer
Author:	Jane Milligan, NE London Accountable Officer
Committee(s):	None so far.
Public / Non-public	Public

Executive Summary:

The document attached is the NE London Sustainability and Transformation Partnership response to the NHS England Long Term Plan.

It is currently in draft format and is being attached for information and discussion at the 10 October City & Hackney Integrated Commissioning Board.

The NE London Sustainability and Transformation Partnership is asking for stakeholder feedback on this document by the end of October 2019.

Recommendations:

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

- To **NOTE** the report;

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

- To **NOTE** the report;

Strategic Objectives this paper supports

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	The STP LTP is a NE London-wide document and thus affects and supports all of City & Hackney's strategic objectives.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	
Ensure we maintain financial balance as a system and achieve our financial plans	☒	
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	
Empower patients and residents	☒	

Specific implications for City

None.

Specific implications for Hackney

None.

Patient and Public Involvement and Impact:

Not applicable as this is a NE London-wide document. This document has been drafted with the input of patients and the public and they will continue to be involved as this moves beyond draft stage.

Clinical/practitioner input and engagement:

As above.

Equalities implications and impact on priority groups:

Equalities implications will form the basis of service design on every aspect of the long-term plan as it is drafted and implemented however there are no direct equalities implications as a result of sharing this draft with the City & Hackney Integrated Commissioning Boards. The STP has conducted an Equalities Impact Assessment on this document.

Safeguarding implications:

None.

Impact on / Overlap with Existing Services:

None.

Strategy delivery plan incorporating north east London's response to the Long Term Plan

Draft for submission to NHS England

27 September 2019

Contents

About this document

This Strategy Delivery Plan is north east London's response to the Long Term Plan. It is a first draft, submitted in order to meet NHS England and Improvement's deadline of 27 September 2019 and as such some content is missing or needs revising.

A final version will be submitted to NHS England on 15 November 2019. Over the next six weeks, we will further revise and update this document, ensuring the final version incorporates more detail regarding:

- Housing challenges in north east London
- Social care
- EU exit and the implications this will have on delivering a health and care service
- Specialised commissioning
- Patient safety and experience
- The most up to date workforce data
- Feedback from engagement activities
- Feedback from our 16 October stakeholder event
- Feedback from patients, the public and staff
- Exploring flexible working
- Financial strategic framework
- Further clarification of the WEL system model

Sections of this draft have been posted on our website www.eastlondonhcp.nhs.uk and promoted via partners and social media channels to encourage people to comment before it is finalised. Further engagement on our draft Plan is planned (see chapter 8 for more detail).

CHAPTER 1 – INTRODUCTION

Foreword

Our plan to deliver integrated health and care for the people of north east London

This is our draft Strategy Delivery Plan for the five year period from 2019/20 to 2023/24. It sets out how we will all work together to respond to our known challenges including expected population growth with people living longer and with multiple complex conditions. We are committed to delivering improvements in areas like caring for our older and vulnerable residents, providing information to help people live healthier and more active lives, and giving our children the best possible start in life.

The NHS Long Term Plan, published in January 2019, set out an ambitious vision for the NHS over the next ten years and beyond as medicines advance, health needs change and society develops. It outlined how the NHS will give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well. We have used the publication of the national Long Term Plan as the context to refresh our 2016 strategy for health and care, and this Strategy Development Plan is our response to this, developed by our providers, commissioners, local authorities, our public and our local voluntary sector.

As a system we are committed to working together in a collaborative way to deliver local health and care services which mean our local people have more options, better support and properly joined up care at the right time in the best care setting. Integral to this will be how we develop our north east London Integrated Care System (ICS) by April 2021. ICSs bring together local organisations in a pragmatic and practical way to deliver the 'triple integration' of primary and specialist care, physical and mental health services and health with social care. They will have a key role in working with local authorities at 'place' level and through systems, commissioners will make shared decisions with providers on population health, service redesign and Long Term Plan implementation.

The following plan sets out how we will translate, take forward and deliver our ambitions, building on our achievements to date and our well established collaboration with partners and ensure that we face our challenges head on to provide and deliver sustainable and high quality health and care for all our residents.

Barking and Dagenham Clinical Commissioning Group City and Hackney Clinical Commissioning Group Havering Clinical Commissioning Group Newham Clinical Commissioning Group Redbridge Clinical Commissioning Group Tower Hamlets Clinical Commissioning Group Waltham Forest Clinical Commissioning Group Barking, Havering and Redbridge University Hospitals NHS Trust Barts Health NHS Trust Homerton University Hospital NHS Foundation Trust East London NHS Foundation Trust North East London NHS Foundation Trust	London Borough of Barking and Dagenham City of London Corporation London Borough of Hackney London Borough of Havering London Borough of Newham London Borough of Redbridge London Borough of Tower Hamlets London Borough of Waltham Forest
In partnership with: Care City UCLP London Ambulance Service	St Francis Hospice, St Joseph's Hospice, Haven House, Richard House, Community and voluntary sector, Partnerships of East London Co-operative

This document and the impact of the Strategy Delivery Plan on equalities

An equality impact assessment (EIA) is a process to make sure that a policy, project or proposal does not discriminate or disadvantage against the following characteristics:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

We are committed to making sure that our Strategy Delivery Plan does not discriminate against or disadvantage people.

We expect all work as a result of this plan to take equalities into account and for each workstream and system to carry out an overarching EIA and publish this on their and our website.

Any proposals for change will require a separate EIA process.

Introduction

The publication of the national NHS Long Term Plan has provided us with the backdrop to refresh our 2016 STP Plan, in order to best meet the needs of north east London residents.

The challenges we face over the next five to ten years are stark, and cannot be addressed simply by doing more of the same:

- We are facing substantial population growth (from 2.02m to 2.28m by 2028, 13% growth over the next 10 years).
- There are significant variations in clinical quality and outcomes across our health and care economy that need to be tackled in order to make a real impact on health inequalities.
- We already have a significant workforce challenge across both health and care services (add numbers of vacancies - HEE data submission post-27/9) and our population growth will exacerbate demand for services if we continue to deliver them in the same way.
- Demand is projected to outstrip our resources and capacity which means we need to look at how we provide care and our financial models and systems. These challenges span both health and social care, and mean we need to agree a different way across all our partner organisations to manage financial risk.

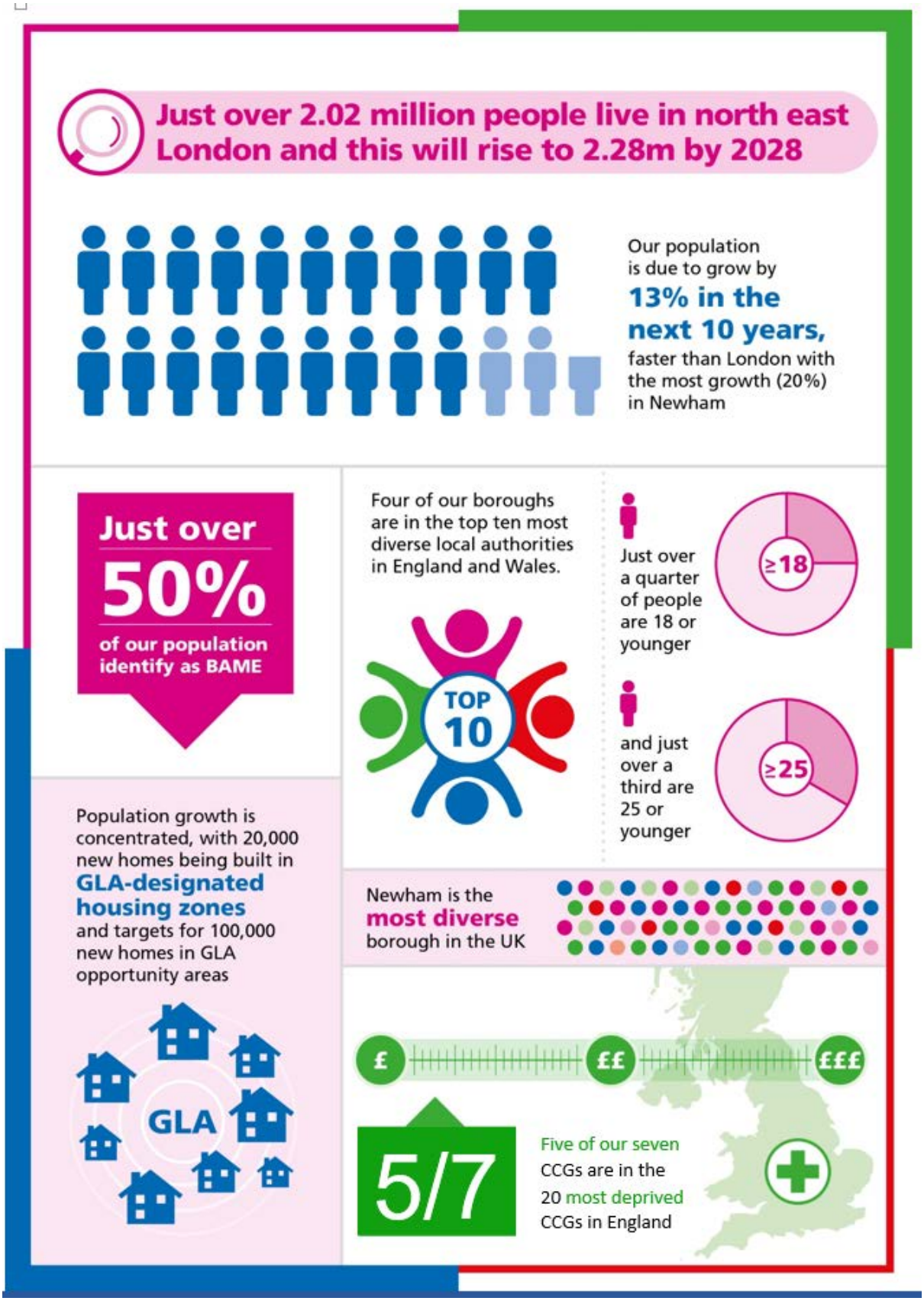
In order to continue to respond to the health and care needs of our local population we therefore need to do things radically differently.

Our response needs to be three-fold:

- Greater emphasis on preventing ill health, and empowering local people to take more control over their health and lifestyle choices (prevention and personalisation)
- Ensuring the health and care services we do provide are integrated, joined up and appropriate for people's needs (integrated care)
- Rapidly modernising local approaches to health and care provision, utilising the academic and research base we have in north east London for the good of our local population (modernisation).

This plan outlines how we intend to deliver on this ambitious agenda over the next five years, and in doing so provides our north east London response to the national Long Term Plan.

A snapshot of north east London

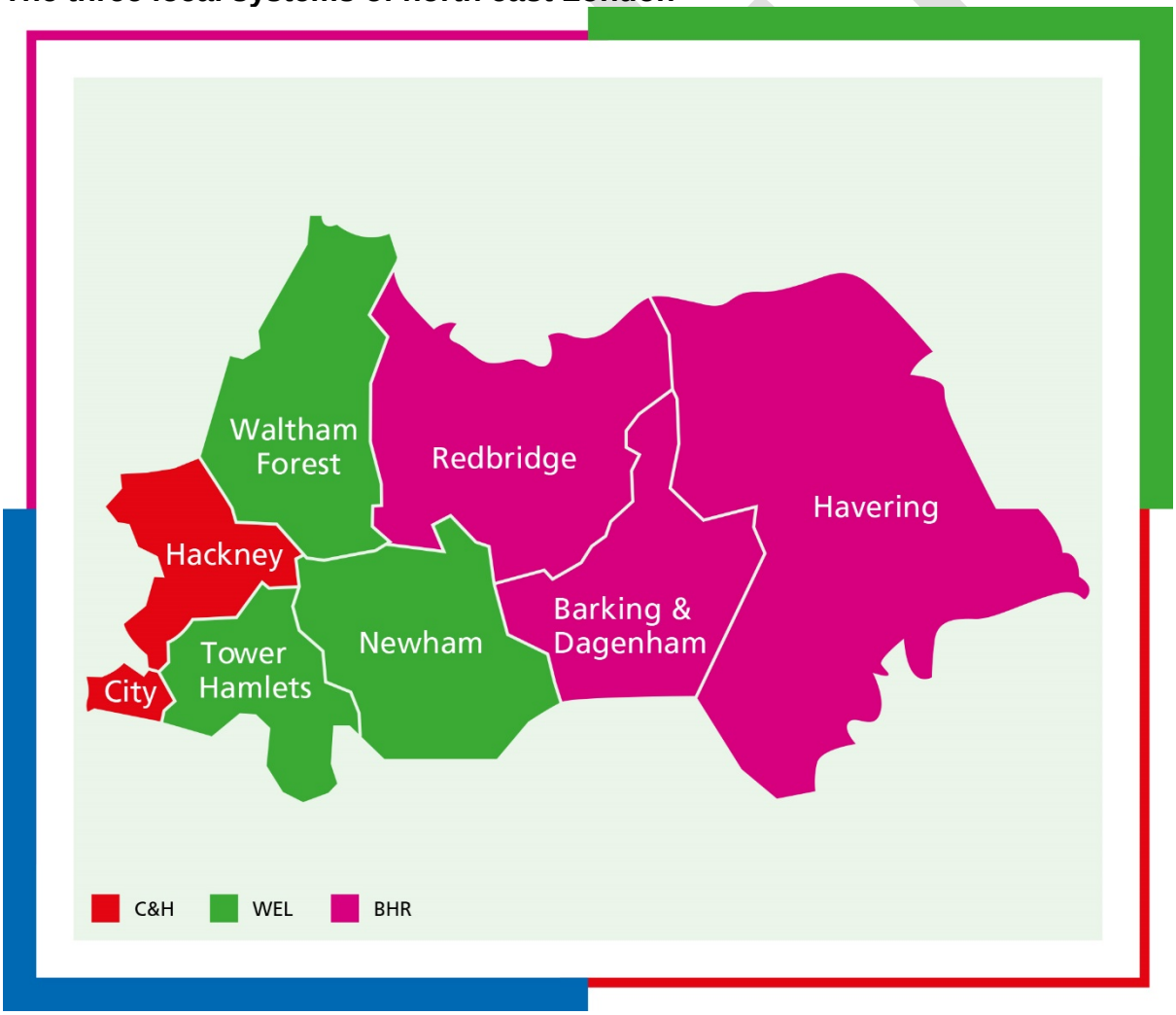


About north east London (NEL)

North east London is a vibrant, diverse and distinctive area of London steeped in history and culture. The 2012 Olympics have regenerated much of Stratford and the surrounding area, bringing a new lease of life and enhancing the reputation of this exciting part of London. This has brought with it an increase in new housing developments and improved transport infrastructure and amenities. Additionally the area is benefiting from investment in health and care facilities with a world class life sciences centre in development at Whitechapel and confirmed funding for a new health and wellbeing hub on the site of St George's Hospital in Havering, making it an exciting time to live and work in north east London.

In terms of health economies (sustainability and transformation partnerships) overseen by one Accountable Officer by population, north east London is the second largest in England, with a population of over two million people and a predicted population increase of 13% over the next ten years. The NEL footprint covers the local authorities of City of London, Hackney, Tower Hamlets, Newham and Waltham Forest through to the outer north east London boroughs of Redbridge, Barking and Dagenham and Havering. There are seven CCGs, five NHS Trusts (three acute and two community and mental health), 284 GP practices, 320 dental surgeries, 47 primary care networks and three local systems: Barking and Dagengam, Havering, Redbridge, Waltham Forest and East London and City and Hackney.

The three local systems of north east London



Our population is made up of over 1.1 million adults, 430,000 children, around 204,000 older adults and 251,000 young adults. Just under half the population (47 per cent) identify as white, around 20 per cent as Asian and 14 per cent as black with the remaining population identifying as mixed ethnicity (7.5 per cent) or other (5 per cent). In total over 100 languages are spoken across the area. Local residents are a mix of transient young professionals to families spanning generations.

This diversity and variation brings a huge richness to the life of north east London, but in providing services it can bring a number of challenges. As a health and care system we came together in 2016 to respond to these in the format of a Sustainability and Transformation Plan. This plan brought together system partners for the first time under the East London Health and Care Partnership banner to respond to challenges including:

- childhood obesity
- high deprivation with high proportions relying on benefits, experiencing fuel poverty, unemployment and poor housing and environment
- service quality issues including a high reliance on emergency services, late diagnoses and treatment and access to services particularly primary care
- workforce recruitment and retention issues

Since then we have made improvements in quality and performance, innovation and service development, progress on integrated care and on developing our local workforce, working in close partnership with our health and care colleagues. Achievements to date include:

- a NEL wide integrated clinical assessment services (CAS) NHS111 has been rolled out across north east London. This involves a multidisciplinary team of GPs, pharmacists, dentists, nurses, paramedics, and health advisors providing expert advice over the phone.
- a system wide estates strategy has been developed and agreed.
- strong place based delivery systems have been developed across City and Hackney, WEL and BHR.
- the East London Patient Record has been rolled out across WEL and C&H and is underway in BHR. Usage has doubled in one year (currently 112,000 views per month)
- an ERS (Electronic Records) programme has been delivered and paper switch off achieved for outpatient referrals to hospitals across NEL.
- £5.2m has been secured for the first rapid access diagnosis centre in England, which will open in early 2020.
- Significant improvements in the Care Quality Commission (CQC) ratings for our hospitals and GP practices.

Additionally across London we are working with partners to develop and deliver a London vision for health and care which aims to make London the healthiest global city. As a London wide system we are committed to a focus on ensuring our residents start well, live well and age well. This vision outlines a commitment to dealing with childhood obesity, improving the emotional wellbeing of children and young Londoners, making progress towards zero suicides, improving air quality, tobacco control and reducing smoking, violence reduction, improving the health of homeless people, improving services for HIV and other STIs, and supporting Londoners with dementia to live well.

As a partnership we have used the opportunity of developing the London vision, and our response to the Long Term Plan, to review and refresh our shared vision for health and care. Our partners have agreed the following strategic vision:

- Delivering a 21st century NHS for our local population using the opportunities afforded to us by new technology, quality improvement, urban regeneration, research opportunities, and new models of care that we have already been piloting in NEL.

- Addressing the significant health inequality challenges for our local population, particularly by improving primary, community and mental health care, promoting earlier and faster diagnostic services, and working with our local authority partners to tackle many of the wider determinants of health (such as housing, air pollution, and promoting a culture of personalised care).

- Pioneering a new approach to the health and care workforce, promoting recruitment from our local population through apprenticeships and training opportunities; we will build and expand our approach to develop new and exciting roles enabling our staff to have portfolio careers.

- Taking a different approach to services for the young and the old in our communities. We will take our ambitions on maternal health further, ensuring we have a holistic approach to the health of our 0-25 year olds that dovetails with their social and educational development. For our older people and others with long term health conditions we will pioneer holistic and less dependent models of care, particularly through personalisation and placing prevention at its centre.

- Taking a visionary approach to finance, making population health our key financial driver and investing properly in prevention and longer term planning.

Underpinning our vision is an absolute commitment to involving local people in decision-making.

This document sets out how we as a health and care system in north east London will take forward these ambitions, building on our achievements to date and our well established collaboration with partners to face our challenges head on and provide sustainable and high quality health and care for all our residents. It outlines our ambition to become an Integrated Care System (ICS) by April 2021, comprising our three distinct local systems: BHR (Barking and Dagenham, Havering and Redbridge), WEL (Tower Hamlets, Newham and Waltham Forest), and City and Hackney (C&H) based on their local populations.

How we have developed our strategy delivery plan

Our engagement around the Long Term Plan has been conducted at local place, local system and NEL-wide level. The approach to each has been deliberately bespoke as each of our areas have established engagement methods in place. This has involved a range of approaches and methods including:

- Informal discussions
- Public meetings and events
- Focus and specialist groups
- Regular stakeholder and staff newsletters
- Social media
- Videos
- Surveys – online, paper, through networks
- Media channels
- Meetings with community and voluntary groups and Healthwatch

Engagement has taken a two-pronged approach. Our local Healthwatch organisations have focused on face to face engagement with identified seldom heard groups in our communities, while partners have focused on using online communications and engagement channels and existing patient groups and meetings to gain feedback from the wider public and key stakeholders.

Through this period of engagement, we have tried to make sure we:

- hold open, clear informed and collaborative conversations
- seek and listen to views of our partners, patients, carers and local people
- make engagement core to our work
- are honest and open in discussing the challenges we face as a system to the delivery of services
- inform wider stakeholders of the plan – to build understanding and support for the approach we are taking as a system.
- build our reputation as a group of organisations working collaboratively in the common, rather than individual, organisational interest
- are clear to people about how their feedback has contributed to the plan.

Healthwatch-led engagement
The eight Healthwatch organisations across north east London were commissioned to host two focus groups and complete 250 NEL-specific questionnaires in each borough. It was agreed that they would focus on the following priority areas:

- primary care
- prevention
- personalisation

NEL Healthwatch spoke to almost 2,000 people during a short engagement period to capture the patient voice on the NHS Long Term Plan (LTP) and completed 1275 regional patient surveys. Following this NEL Healthwatch developed the following recommendations for prevention, personalisation and primary care:

Healthwatch recommendations

Prevention	• Work collectively and collaboratively to improve access to health care (GP and health professional) appointments with a view to reducing waiting times for GP and health professional appointments. • Adopt a regional approach to producing and disseminating prevention information that is accessible and relevant to NEL communities. • Co-create NEL Information and Signposting solutions that can be co-located (in GP surgeries, community pharmacies) and adequately inform residents about health, social care and wellbeing services.
Personalisation	• Co-produce information and signposting resources and support with social care providers, CVS, social prescribers, patients, carers and service users. • Develop a quality improvement project to improve patient access to gp appointments including identifying examples of best practice and sharing learning within NEL. • Work with partners and stakeholders to co-create better patient carer education ensuring that information and support is accessible to relevant client groups.
Primary care	• Work with NEL communities to explore the possibility of GP surgeries becoming hubs for health and wellbeing offering: improved access to GP/health professionals, site based services (blood testing, physiotherapy, alternative therapies) and support (information, advice and guidance). • Work with community pharmacies to improve local offer to communities, carers and service users in terms of prevention, personalisation and primary care. • Make it easier for patients to book primary care appointments (GP, health professional, and dental), manage medical records and order repeat prescriptions online.

We are working with Healthwatch to explore how we can best work together to work through and deliver the recommendations, and to feedback to local people how their comments have contributed to the plan, and how we will take forward their recommendations.

Spotlight on: The Citizen's Panel

Established with funding from NHS England, the ELHCP citizens' panel has over 1,100 members and is used to gain insight and feedback from a demographic of local people aged 16 and over. The panel provides a quick and easy way for the people of NEL to be involved in shaping our commissioning plans, priorities and service redesign. The objectives for the panel are:

- to continue to increase patient and public involvement in shaping and commissioning services
- to continue to increase the use of public insight in commissioning and service delivery decisions
- to continue to build a demographically representative online panel of people who want to support the ELHCP in shaping services
- to expand engagement methods of the citizens' panel to provide wider range of engagement types (e.g.. online discussions, interactive surveys)
- to increase response rate to engagement.

The panel is just one way ELHCP are giving people an opportunity to influence local health and care service by sharing their views, experiences and ideas to help shape service that meet the needs of local people. It doesn't replace other ways to engage, e.g. patient engagement forums, consultations, face to face events – it is part of a wider engagement strategy.

Findings from surveys have been shared with workstream leads to provide qualitative and quantitative data, which is used alongside a range of other data to help workstreams at key points in projects, service design, or commissioning. We continue to keep panel members updated on how their feedback is being used.

Summary/chapter highlights

We have undertaken extensive engagement with our local residents on how we refresh our strategy for health and care in light of the national Long Term Plan commitments. We have done our best to reflect their views and priorities in this draft Plan.

During October we will be conducting even more intense engagement on this Plan now that it is in a draft form. This will include more engagement in local areas with residents and their representatives, additional engagement through local Healthwatches, and seeking the views of all our staff who will be key to successful delivery of the finalised Plan.

The most pressing challenge we face as a health and care system is our significant population growth, and this Plan outlines the way in which we will ensure that we are collectively prepared to face this challenge. We are using the period from now until we produce our final draft to agree a delivery plan focused on:

- How we will tackle demand in a meaningful way, focused on addressing the social determinants of health rather than simply trying to alter traditional referral patterns.
- How we will deliver real integrated care for our local residents through improved and responsive out of hospital services that are able to support people living with greater levels of health and care complexity. This will include agreeing exactly what we expect to deliver at each of north east London, local system, place (borough/local authority), and network levels.

- How we will ensure that we have the most appropriate clinical services to support our population needs. During October we will secure agreement across all of our health and care system, using the Clinical Senate, on the clinical priorities we most need to focus on (which are likely to include maternity, children's services and mental health).

Further work is now underway to refine the Plan as we triangulate the information that we have on workforce planning, activity and finance as this becomes clearer during October.

CHAPTER 2 – INTEGRATED CARE SYSTEM DELIVERY

A critical part of our overall plan is the development of systems and structures to deliver integrated care. We will be establishing an Integrated Care System (ICS) across north east London by April 2021, building on the strong foundations of three existing local systems. We will work closely with the other ICSs in London to enable the Mayor's aspiration of making London the world's healthiest global city, with residents receiving the best health and care services.

To make a real difference to local people we plan to anchor delivery systems as close as possible to where people live. We have already seen the impact of this approach for delivering improvements across a range of long-term conditions for our local residents, where services have been built up around neighbourhoods – what we are now calling Primary Care Networks - and referred to in this Plan simply as Networks. In City and Hackney and Tower Hamlets, in particular, Networks of general practices have been working together for over a decade with many social care services wrapped around the same geography to ensure delivery of care is more integrated and tailored to individual and family needs. Although these alliances are less mature in our five other local authority areas, this plan will give us the ability to fast-track the development of Networks based on our exemplars, and transformation funding will be utilised in each of the years covered by the plan to develop and enhance Networks across the patch. Through these changes we will ensure that the patient and service user's perspective is at the centre of service delivery and planning across the whole of north east London.

Our 47 Networks map directly onto local authority areas, where close partnerships have been developed between health and care to deliver consistent and joined up services for both adults and children, which reflect the needs of the local population. These place-based partnerships vary across the patch; each of them will benefit from borough-based joint commissioning arrangements as well as leadership and accountability through to Health and Wellbeing Boards. As a Partnership we are committed to developing this model further, enabling place-based decision making and resource allocation jointly across health and care on a population basis. We describe how this looks in each area later in this chapter.

Making integrated care happen

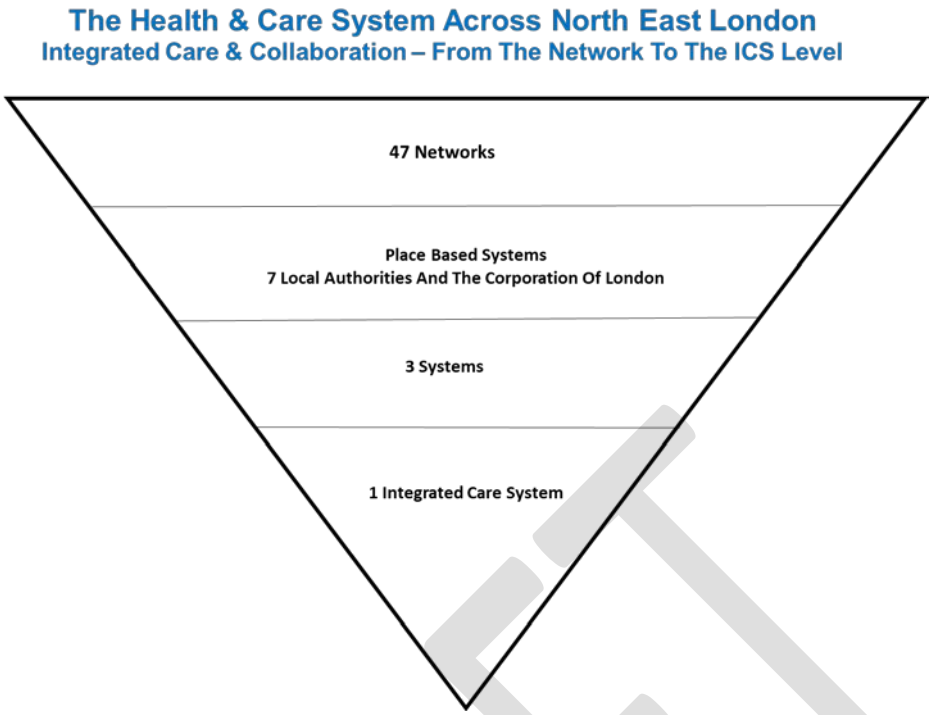
The shift towards integrated care will be supported by increased investment in primary, community care and mental health services, as well as by the creation of much more integrated working across health, social care and the voluntary sector at a neighbourhood level. We will also initiate a fundamental shift in the way the NHS operates, moving on from a culture of competition based on the separation of commissioners and providers, to a new approach based on co-operation, collaboration, integration and system-based working. Our providers will not just be responsible for the people they treat, but will also have a collective responsibility for the whole population's health alongside commissioners. We will support people and organisations to change their systems, processes, behaviour and culture as we move towards these new ways of working. Our focus will be on strengthening clinical leadership, enhancing partnerships with our local authorities and embedding patient and public engagement across our ICS. These cultural changes will take time, but we believe that as trust builds and new leadership behaviours become established, this more collaborative system approach will lead to improved population health outcomes. It is also our ambition that these changes will enable north east London to become a more exciting and attractive place to work. We will offer more flexible and varied opportunities to staff across the whole system: jobs and roles linked to population health rather than traditional NHS institutions.

Our north east London integrated care system for patients, residents and staff
We will establish a single Integrated Care System (ICS) across north east London by April 2021. It will be supported by a single north east London CCG, three strong local systems (BHR, C&H and WEL), eight local authorities and 47 primary care networks. The roles and responsibilities across each level of the system are outlined in the below table and diagram.

Summary of north east London integrated care system

Networks	• Serving populations of 30,000-50,000 people • Integrated multi-disciplinary teams • Primary care networks across practices and health and social care • Proactive role in population heath and prevention • Services drawing on resource across community, voluntary and independent sector, as well as other public services like housing
Place based systems	• Serving local populations in line with local authority geographies • Integration of hospital, council and primary care teams/services • Develop new provider models for 'anticipatory' care • Models for out of hospital care around specialities and for hospital discharge and admission avoidance
Local systems	• WEL (Waltham Forest, Tower Hamlets and Newham), BHR (Barking and Dagenham, Havering and Redbridge), City and Hackney • Collaborative working between providers • Strategic partnerships • Provision at scale
Integrated Care System	• System strategy and planning • Develop governance and accountability • Implement strategic change • Manage performance and collective financial resources • Identify and share best practice across the system

Our approach to change is to build from the bottom up and decentralise decision-making locally with decision making as close to local people as possible.



Networks will be the key building block and the focus of integrated care delivery. We will ensure there are strong links to Networks via planning based on local authority footprints, so that new care models can work seamlessly across health and social care. This place-based planning will link to one of our three local systems, which have grown up organically based on the strength of local partnerships and the need to shift the emphasis and settings of care from the hospital to the community. The three local systems correspond broadly to the patient flows for our three main acute hospital Trusts, and each of these has very strong leadership from community, mental health services and local authorities that are shaping their development.

The single CCG for north east London will have a leading role in this new integrated care system. With partners, it will be responsible for:

- Improving outcomes, reducing inequalities and increasing quality of care for citizens, patients and their families
- Achieving financial sustainability across the system and making the best use of taxpayers' money
- Creating a rewarding and satisfying place to work for staff

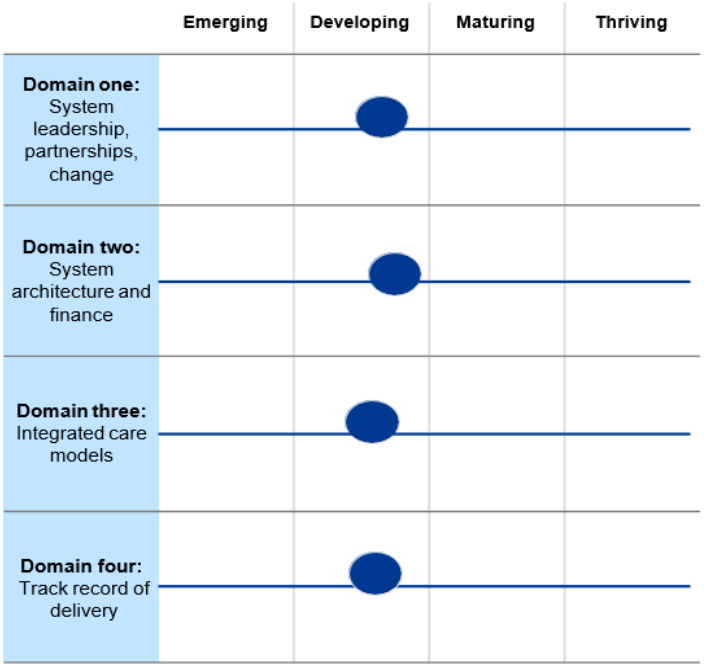
Achievements to date

As a Partnership we will hold ourselves to account for delivering these improvements across integrated care. We have many of the governance and systems in place to achieve this goal:

- We established the ELHCP in 2016, bringing together our local authorities, NHS Trusts and clinical commissioning groups to oversee system development. It has focused on service and infrastructure changes that are best planned and delivered once for north east London, with an independent chair in place. The ELHCP will transform into the NEL ICS by April 2021.
- We created the North East London Commissioning Alliance (NELCA) in 2017, which aligned the seven CCGs in North East London supported by one accountable officer and chief finance officer. Key areas of focus for NELCA include: commissioning services jointly including London Ambulance Service and integrated urgent care, specialist commissioning; aligning commissioning strategies for urgent and emergency care, mental health and planned care; and harmonising assurance processes.

- NEL Joint Commissioning Committee (JCC), a committee within NELCA, is a forum where this joint work is being undertaken. The JCC's focus has been on issues that are common to all CCGs, such as a common contracting approach with hospitals, and for a limited set of areas to take decisions about services that are commissioned once for north east London. As we move towards an ICS the lines between commissioning and providing will blur, giving providers more direct responsibility for population health.
- Alongside joint commissioning arrangements, we have seen closer collaboration across providers. For example, within WEL and C&H there is a collaborative partnership between Barts, ELFT, Homerton, NELFT and GP collaboratives, focusing on redesigning key pathways together. Similarly, there is a chair in common at BHRUT and NELFT and we have recently seen the decision to have a joint CE appointed for the two organisations. There is also an ELHCP workstream focusing on provider collaboration between all the Trusts across the Partnership.

Across London we have been working with NHS England and Improvement with respect to our ICS development, using the learning from the national ICS pilots. The assessment of our progress has been agreed as "Developing" (see the chart below) and we are working closely with the London team to ensure that we incorporate the areas for development within our local programme. Discussions have progressed to secure the additional support referred to in the chart.



Areas for Development:

- Accountability Framework: how to get Acute providers to take responsibility for system outcomes. More to do to develop 'system ownership' of NEL plans in all organisations – culture change
- Role of emerging PCN clinical directors (and how they fit with other clinical leadership at a system level) – PCN development has been largely driven at borough level
- Developing operating model at ICS, local system and place level while avoiding duplication. Need real clarity on what happens at each level

Support that would be helpful:

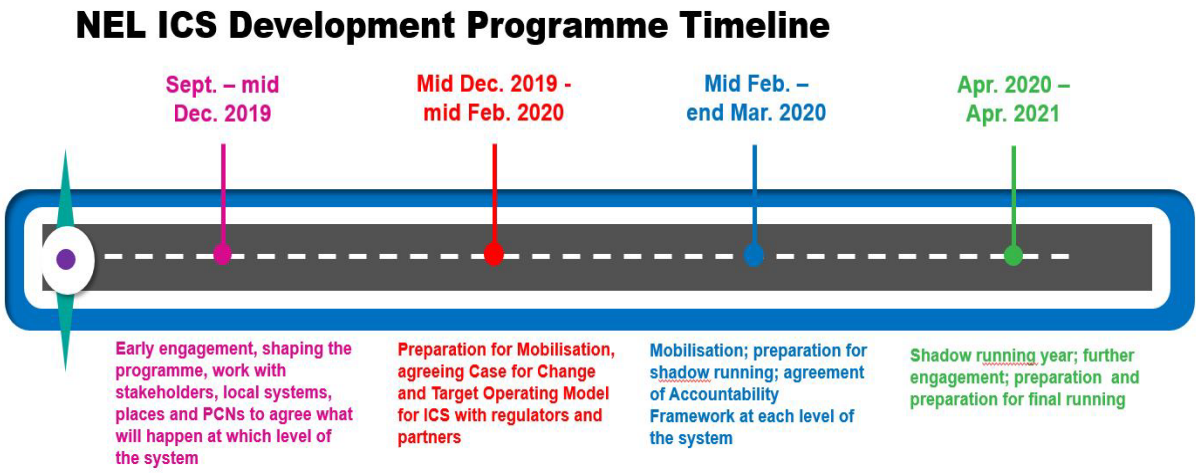
- How to give voice to Primary Care Networks at system level
- Creating a compelling narrative linked to the London Vision
- Talent Management

This summary is not exhaustive

ICS progress assessment (September 2019) for north east London

Over the next few months we will be carrying out the development work necessary to start operating as a shadow ICS from April 2020, including recruiting a new chair for the emerging ICS. This will allow us a year of shadow running to test this new way of working, with the intention of being fully operational from April 2021.

Our programme timetable is outlined below. Early engagement is already underway, and discussions are taking place at each level in our federated ICS. Key to this will be agreeing what will happen at which level of the system, and we anticipate to include this further detail in our final draft of this Plan.



Our local systems

The most important feature of our ICS in north east London is its federated nature, being made up of three distinct population-focused systems: Barking and Dagenham, Havering and Redbridge (BHR), Waltham Forest, Tower Hamlets and Newham (WEL: Waltham Forest and East London), and the City of London and Hackney (C&H).

Each of these systems will develop local priorities based on the needs of their populations, developed collaboratively across organisations and through local engagement. Here we describe the key features of the population of each of our systems, as well as priority areas and the emerging out of hospital model of care. Developing a new model of integrated care for out of hospital services is an overarching priority across the plan. Across all of our systems, these models will be based upon the Network geographies described in the primary care section of this plan.

Networks have a critical dual purpose: firstly, as the model for strengthening primary care and secondly as the vehicle for delivering integrated care via multi-disciplinary teams. They will have a crucial role in supporting people with increasingly complex health and care needs out of hospital, providing care closer to home and maximising how community resources are used. They will have a comprehensive offer to patients that encompasses physical and mental health, as well as social care and voluntary sector services. The national service specifications for networks that will be released in April 2020, in particular those covering enhanced health in care homes and anticipatory care, will outline the expectations on commissioners and providers for creating integrated care at a Network level. We have outlined the current local service models in place to support integrated care, and in chapter four of this draft we describe the work underway to support the development of Primary Care Networks (PCNs) on local delivery will happen.

Each local system, with its PCNs and Councils, is developing a more detailed bespoke delivery plan aligned with their system focused priorities and we have reflected these in this Plan only in summary form. Overall, each local system's role will be to:

- Remove organisational boundaries to promote organisations to collectively treat a person enabling better coordinated, more seamless and responsive care bringing together not only health and social care, but a range of other services that are critical to supporting our population to live healthy lives.
- Achieve more effective use of resources as organisational barriers that result in duplication and waste are removed.

- Shift resources to promote a greater focus on early intervention and prevention activities; promoting individual empowerment and self-care for people to manage their own health and wellbeing and to live a healthy lifestyle and live independently for longer.
- Support primary care through networks to work at scale.
- Enable the creation of a digital platform across the system that supports population health management and personalised care plans.
- Utilise all community assets.
- Promote a change in culture and working practices so that our health and care workforce is united together as one team
- Promote a shared vision, focused on improving outcomes, underpinned by a new form of contract, payment and incentive mechanisms.

Barking and Dagenham, Havering and Redbridge local system (BHR)

Covering the three London boroughs of Barking and Dagenham, Havering and Redbridge, the BHR system serves a population of 760,000 people and is a long established partnership. It has a diverse, highly mobile and in some cases very deprived population – all with unique health and wellbeing needs, who often find it challenging to access the right service, in the right place, at the right time.

The three boroughs have distinctive features: Barking and Dagenham has a younger and ethnically diverse, mainly deprived population, Havering an older, largely white population, and Redbridge an ethnically diverse, majority Asian, median income population. BHR's population has been increasing rapidly and is projected to continue to rise for the next two decades.

Population growth will result in considerable increased demand for both health and social care. Developing the integrated model for service delivery locally will be a key priority for the BHR system, to ensure resources are directed to BHR residents in the most efficient way possible.

The BHR system is a collaboration between health and care commissioners and providers who have a strong and long history of working together. System leaders are all members of the BHR Integrated Care Partnership Board, which has as its mission the commitment to work together to develop a joint approach to integrated care locally.

Working collaboratively in BHR

As part of the journey towards developing integrated care in BHR, NELFT and BHRUT have agreed to work more closely together. Breaking down barriers between health organisations is a priority and this is intended to benefit patients and staff as more integrated services are developed across mental health, community and acute provision, improving the quality of the care provided. Each organisation will be able to learn from the best practice being pursued by the other. One example of where this is already happening across BHR is the work across providers and commissioners to establish one rehabilitation ward for stroke patients and one community based rehabilitation team. It is anticipated that this will bring considerable benefits for developing primary and community services at Network and borough level.

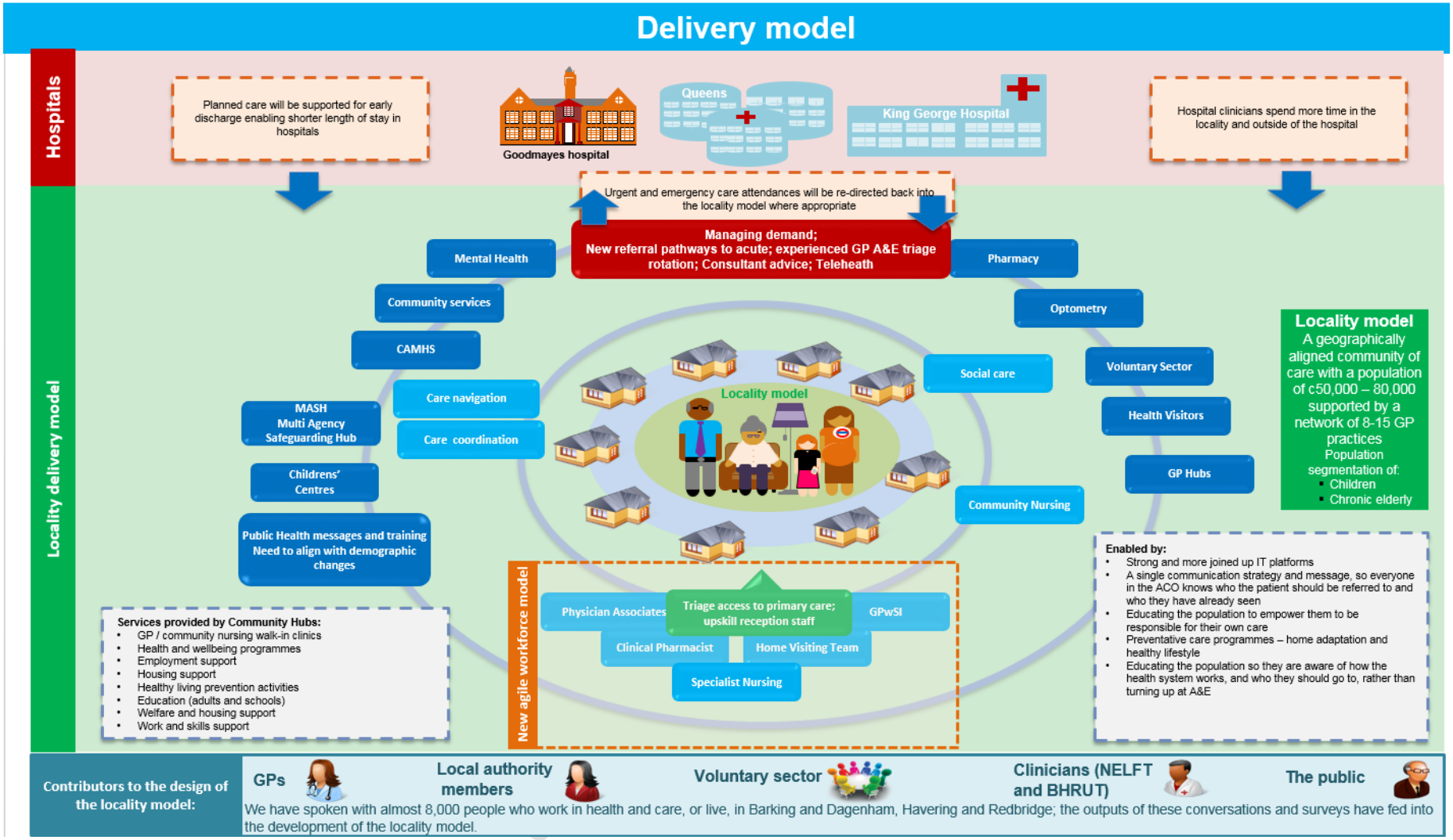
Aims and priorities

At a whole population level a new system will be built around the population rather than institutions. It will be one that bends the curve of future health care demand by addressing the wider determinants of health and building social capital by mobilising citizens, local employers and the voluntary and community sector. BHR's ambition is to shift significantly

investment and monies towards prevention and locally delivered health and social care, away from acute based services as people receive the right advice and care.

Transforming out-of-hospital care and fully integrated community-based care
The BHR locality delivery model (see next page) will ensure a geographically aligned community of care with a population of c.50,000 to 80,000 supported by a network of 8-15 GP practices. There will be a specific focus on a population segmentation of children and the unwell elderly. Services will be provided by community hubs, with developments such as Barking Riverside offering opportunities to develop new models of care for the local population. Multi-professional working across health and social care will be a key component of the locality model, with the development of care navigation and co-coordination supporting care by the right person, and the right place and right time.

BHR delivery model



Spotlight on: Barking Riverside development

An exciting new development at Barking Riverside takes a new approach to the health and wellbeing of local people – with health, leisure, education and a host of other facilities all in one place.

In less than fifteen years, the development will see nearly 11,000 new homes and around 22,000 more residents alongside a dynamic, comprehensive health and care infrastructure to support the growing population.

This ground-breaking development was one of NHS England's *Healthy New Towns* Demonstrator Sites, the only one of its kind in London.

From 2022, Barking Riverside residents will be able to register with a new wellbeing hub providing flexible, joined-up services, centred on each person's needs. The hub's services will focus on preventing ill-health, promoting wellbeing, getting things right first time and improving health outcomes for all.
For example, the planned health and wellbeing hub in Barking Riverside will include:

- Community-curated spaces where local people will be able to contribute to the appearance and function of the building, for example, through taking part in community art groups.
- 'Universal' space – areas that can be used flexibly for a range of purposes.
- Specialist clinical areas, shared between several services.
- Co-located back-office functions such as administrative support; enabling better communication between services and a more person-centred approach.

The hub will be near to education centres such as Riverside Campus School and Rivergate Primary School. There will also be easy access to walking and cycling routes, as well as a focus on cafes and restaurants selling healthy and nutritious food.
Beyond the health and wellbeing hub, the developers and their partners in the health and care system have sought to develop innovative health and care provision in an innovative way.

A 'model of care group' with health, care and community partners working together has sought to co-produce approaches to health with residents. This has seen workshops and more traditional engagement supplemented by river walks, community events built around culture and cuisine, ethnographic research and work with local residents' associations
One of the health and care elements strengthened by this approach was social prescribing. The area was the first to adopt the HealthUnlocked social prescribing plug-in developed within the Care City Test Bed, enabling quick, simple social prescriptions without the need for additional mediating staff.

The findings of this initial work were presented to local people who as a result were inspired to set up their own community groups that people could be referred onto. A fund was created for community groups to bid to for support, specifically for those with depression and/or anxiety, and established that the impact of the group would be evaluated. As a result of this, three new groups providing talking therapies and peer support are being funded and delivered in community spaces in the Thames Ward area.

Barking Riverside is seeking to bring together efforts to improve health services and the wider determinants of health, to make long-term change to the health of north east London, in partnership with communities.

City and Hackney local system

The City and Hackney local system covers the City of London and the London Borough of Hackney. The total population is 283,600: Hackney has 275,900 residents, the City has 7,700. While the City has a low permanent-resident population compared to other areas, more than 400,000 people travel to work here every weekday. There are 322,616 people currently registered with a local GP practice. The local population has been growing faster in recent years than in other parts of England, although not as rapidly as in other areas of north east London.

The City and Hackney system's vision is for all residents deserve to live the healthiest and most fulfilled lives possible. Adults and families want to feel connected to their neighbourhoods, to access high quality care near their homes and in hospital when they need to. Since 2016, local organisations who deliver and commission care in City and Hackney have been collaborating to provide better and more joined up services for City and Hackney's residents through the local integrated commissioning and care programme.

Aims and priorities

There are five strategic objectives for the C&H programme:

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

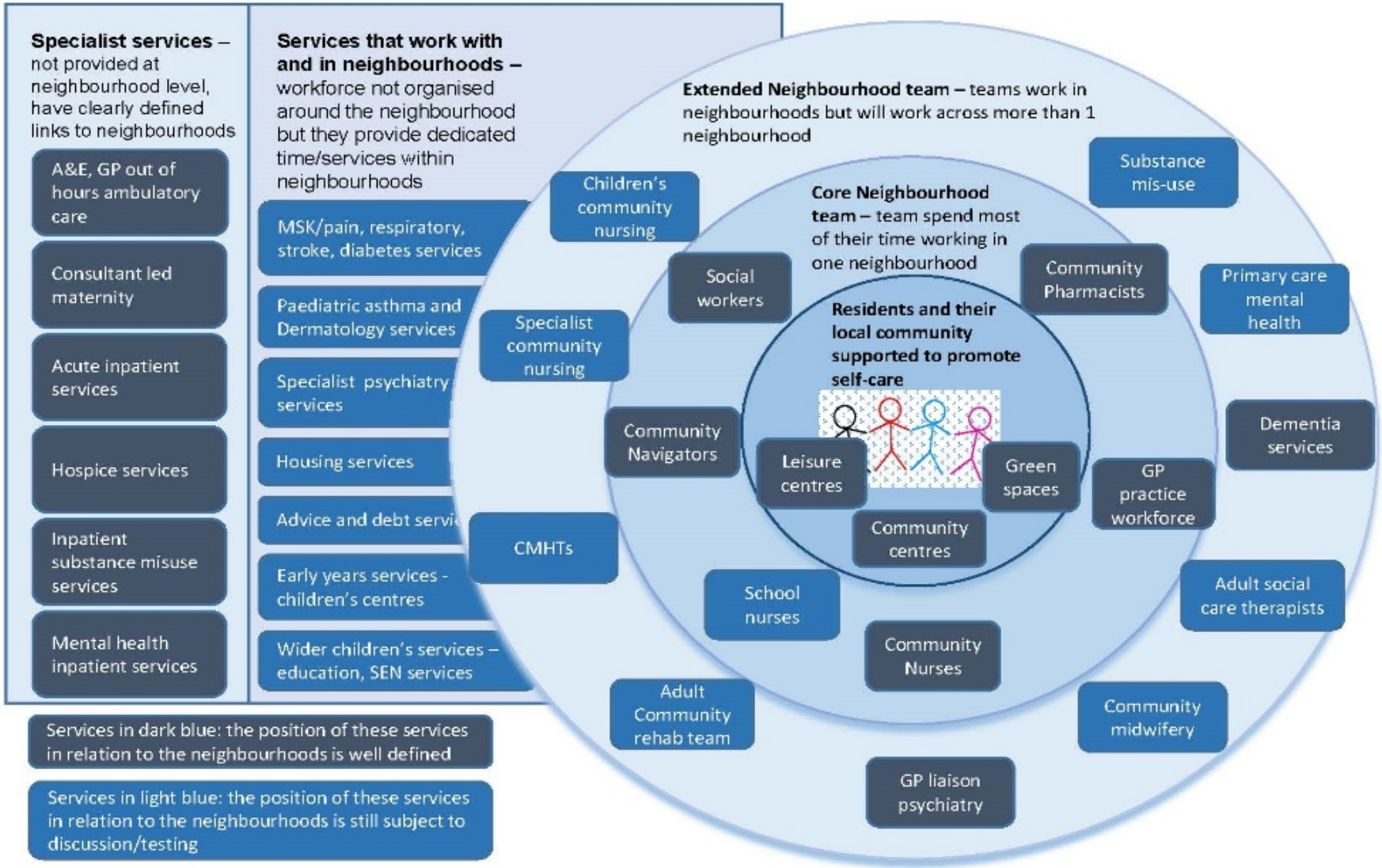
To ensure that everyone understands how the strategic objectives of the programme are aligned to outcomes that matter to residents and patients, City and Hackney system partners have co-produced an outcomes framework which is co-owned with residents. The neighbourhoods programme is in the process of re-designing primary and community services in order to deliver locally integrated health and care services that are responsive to local residents, and support them to stay well. Local GP partners who are already engaged in the neighbourhoods programme, have established primary care networks (PCNs) to be coterminous with the eight neighbourhoods, and there is a focus on improving district nursing as well as care navigation work.

City and Hackney neighbourhood delivery model

This programme will support the redesign of community services to provide increased support within a multidisciplinary context for people with long term conditions. This model will combine psychosocial and medical approaches as well as ensuring links to access community and voluntary sector services.

A Community Services Development Board has been working with the local Provider Alliance of the Homerton University Hospital FT (as provider of community health services), East London Foundation Trust (ELFT, our provider of community mental health services) and the City and Hackney GP Confederation, collaborating with local authority provider partners. They will establish a joint framework for integrating and transforming out-of-hospital services in partnership, based around the Neighbourhoods delivery model.

City and Hackney neighbourhood delivery model



The WEL local system (covering Waltham Forest, Tower Hamlets and Newham)

The partnership of the three boroughs of Waltham Forest, Tower Hamlets and Newham are known collectively as WEL (Waltham Forest and East London). In contrast to other local systems, the WEL system operates strongly focused place-based partnerships:

- Tower Hamlets Together (which was a national Vanguard site)
- Newham Wellbeing Partnership
- Waltham Forest Better Care Together

Within WEL there are three CCGs and councils and three NHS trusts: Barts Health, East London Foundation Trust and North East London Foundation Trust.

There are a number of challenges shared across the WEL system:

- The highest expected population growth in London over the next five years.
- Amongst the highest levels of mental health need in the country.
- Poor health outcomes including obesity, cancer.
- Healthy life expectancy amongst the lowest in the country.
- Life expectancy lower than the London average.
- A deprived population living for too long with one or more health issues.
- Over-reliance on emergency services, with late diagnosis and variable access to primary (non-hospital) care.

WEL are focusing on these significant challenges, building on the existing work of place-based partnerships within and across boroughs, ongoing collaboration between trusts, community organisations, councils and commissioners.

WEL system aims and priorities

The following ten priorities have been agreed across the WEL system partners:

1. Outpatients
2. MSK
3. Urgent Care
4. Diabetes
5. Community ear nose and throat
6. Respiratory
7. Children's
8. Frailty
9. Mental Health
10. Primary and Community Care Development

The WEL system has also agreed the following ways of working together, which reflect the importance of the place-based system partnerships:

- One common model across WEL where appropriate, e.g. where care is provided by our common acute trusts, Barts Health, and one approach makes sense; or where one provider plays a critical role in delivering the service across WEL (e.g., St Joseph's in palliative care). Reflecting the diversity of populations across WEL, there will, of course, remain scope to tailor the common model to the needs of particular localities and to tailor the delivery of care to individual patients.
- One shared model where there is not a reliance on one particular provider, but there are clear benefits in delivering better patient care faster without each borough or locality developing their own bespoke models.
- Sharing the lessons learnt by each of the boroughs in developing models that are not common or shared, to ensure that as much effort as possible goes into implementing models. This will apply where there are good reasons for the approach taken by each borough to diverge to reflect local needs.

For example, we will work towards a common model for outpatients, urgent care and for musculo-skeletal services (MSK) across all of WEL, given the reliance on Barts for those services. For outpatients, it makes sense to make one investment across WEL in developing and delivering virtual outpatient clinics and online follow up. For MSK, Barts is again the primary provider of acute services, and hence there should be a common model for the whole pathway. For those with mental ill health, there are currently two providers in WEL – NELFT and ELFT – so we will explore how common the model could be. This scoping work is happening during 2019/20 in order to form a work plan for WEL for 2020/21 and subsequently.

Each of the three place-based partnerships within WEL have a common approach to local care network development, of which primary care networks are the key building block. Each of the partnerships works at a place level cementing the relationships between local authorities and hospital sites within Barts and community services. The place-based partnerships are also held to account for delivery through the councils' Health and Wellbeing Boards.

WEL's place-based partnerships

Newham Wellbeing Partnership (NWP)
The Newham Wellbeing Partnership will drive forward five key changes in 2020:

1. Boosting out-of-hospital care, and reducing the historic divide between primary and community services;
2. Redesign and reducing pressure on emergency hospital services;
3. Giving people more control over their own health, and more personalised care when they need it;
4. Implementing digitally-enabled primary and outpatient care;
5. Increasing the focus on population health and local partnerships with local authority-funded services.

Waltham Forest Better Care Together
The Better Care Together programme coordinates and supports a wide range of integration projects across the borough. It works closely with other change management programmes to share resources and plan strategically for the future, and is currently particularly engaged in planning and developing the service model that will underpin the new Whipps Cross Hospital development and the community services that support this.

Four programmes have been established to deliver the following shared priorities:

1. Promoting wellbeing
2. Ageing Well in Waltham Forest
3. Improving life chances for people with learning disabilities
4. Better mental health

Tower Hamlets Together
The mission of Tower Hamlets Together (THT) is to 'transform people's health and lives, reduce inequalities and reorganise services to match people's needs'.

Local care networks (based on primary care networks) have developed in Tower Hamlets over the last ten years and already many services are now organised by the four localities, such as:

- Extended primary care teams of district nurses and therapists
- Community mental health teams
- Longer term social care teams

- Home care agencies
- Community-based support services (e.g. Linkage Plus).

Locality Health and Wellbeing Committees act as local collaborative leadership forums and are continuing to develop a systemic view of local population assets and needs, and develop a broader network of local organisations and individuals to drive improvements in outcomes (e.g. VCS, care homes, home care, faith groups, schools, etc.). There is significant work underway to support population health improvement on a locality basis, including locality public health leads, locality joint strategic needs assessments, and the communities driving change programme which is a health and wellbeing board priority (along with developing an integrated system).

Spotlight on: integrated sexual health services across WEL and Redbridge

In 2012/13, councils became responsible for the majority of sexual health services including genitourinary medicine (GUM) and Contraception and Sexual Health (CaSH) services. Subsequently, there has been an unprecedented growth in STIs and activity and associated spend alongside some of the lowest Long Acting Reversible Contraception (LARC) levels in the country.

In 2016 Newham, Tower Hamlets, Waltham Forest and Redbridge (WELR) agreed to collaborate to explore alternative models of delivery. Boroughs initiated extensive engagement with residents which identified.

- Residents preferred an integrated sexual health offer, rather than separate GUM and CaSH. This would reduce the number of appointments needed to complete a pathway.
- Between 30-50% of service users would be interested in an online STI testing offer. GUM appointments often required them to take time off work, with long waits to be seen.
- Young people valued the anonymity of services located in multipurpose venues.
- Providing services in GP practices was acceptable to young people but they wanted to be able to choose to use a different practice from their GP to ensure greater anonymity.
- Women would value an improved ‘there and then’ LARC offer. Booking an appointment, often several weeks in the future, reduced the likelihood that they will attend.
- Service users valued modern estates in accessible locations, ideally near major transport hubs.

As a result, WELR Councils agreed to collaborate to commission an integrated sexual health service for the sub region. Barts Health was awarded an integrated sexual health contract, launching the new service model in December 2017. The features of the new approach include:

- A new Centre of Excellence in Stratford, with the historic Ambrose King Centre in Whitechapel undertaking a £2.5m refurbishment. The centres are complemented by a number of nurse led satellites. Overall, 60% of the new sites have either in new or been recently renovated.
- More staff have been dual trained in STI testing, treatment and contraception, increasing resource to deliver LARC. This development has resulted in a 30% increase in LARC uptake.
- The new offer included a digital STI assessment with self-sampling kits available in clinic and through the post. Approximately 15-20% of all specialist STI testing now takes place through the digital offer, reducing waiting times, improving choice and improving patient satisfaction.

- Increase in patient satisfaction for the Barts service and through the digital self sampling service.
- Increase in service users accessing longer prescriptions for oral contraception, increasing patient satisfaction and reducing unnecessary appointments
- Innovative work packages aimed at improving capacity and confidence within primary care, providing clinical leadership for the system, developing detailed insight in areas of concern i.e. HIV within the black community, develop new technology driven Partner Notification models and improve targeted marketing.

WELR Councils have established a shared commissioning and contracting service hosted by Newham. The service has recently developed a pioneering approach to data analysis through Power Bi. This is providing a new level of insight which is informing performance. The next steps include the development of a WEL sexual health strategy, with the aim of reducing fragmentation across commissioning responsibilities and improve service user outcomes and experience. This work will be overseen by the WEL Sexual Health Board, whose members include providers and commissioners.

Our ICS as a part of London

Improving the health of Londoners now and for future generations is something that cannot be achieved in isolation either as an ICS covering one-fifth of the city geographically or as the NHS on its own. That is why we have come together across the capital to work together collectively. This London-wide partnership is made up of the Greater London Authority, Public Health England, London Councils and the NHS. As such the East London Health and Care Partnership (and, in the future, the north east London ICS) is an intrinsic part of this London-wide collaboration.

There is a shared ambition to make our capital city the world's healthiest global city, and the best global city in which to receive health and care services. We are committed to working in partnership across London to address priority issues that require city-wide solutions, as well as supporting each other on a more local level by sharing good practice.

Across London there are a range of strategies that have been developed to support a healthier environment for all who live in and use the capital and it is from these shared priorities that this has been developed.

- The London Vision
- London Clinical Network Priorities
- The Mayor's Health Inequalities Strategy
- NHS Specialist Commissioning London strategic priorities
- Healthy London Partnership (focus areas)
- The objectives of the NHS Long Term Plan that are best met at London level

Each of the following objectives have been identified across London as priorities for action:

Reduce childhood obesity

- Expand the junk food advertising ban in boroughs and on NHS sites
- Increase the proportion of Londoners achieving two ten minute periods of walking or cycling each day.
- London hospitals to adopt the new version of hospital food standards and create more opportunities to support children and families with maintaining a healthy weight. Local action to deliver this priority is detailed in chapter 3.

Improve the emotional wellbeing of children and young Londoners

- Deliver Thrive LDN's "Are we OK London" campaign.
- Roll out of the Trailblazer initiative to establish mental health teams supporting schools. Local action to deliver this priority in NEL is detailed in chapter 4.

Healthy children and maternity services

- Asthma is a particular focus with children's and young people's asthma clinical networks being rolled out across London. Work is being supported by a pan-London awareness campaign #AskAboutAsthma.
- Ensure newborn babies, children and young people access high quality services in the right place at the right time.
- Continue to support the implementation of the Better Births agenda - for local action see chapter 5.

Create healthy environments/healthy places

- Continue to develop healthy environments to live and work
- Action on rough sleeping
- Build a stop smoking London portal
- Control of illegal tobacco and counterfeit alcohol
- Support London employers to receive the Healthy Workplace Award accreditation. Local work on this objective includes the roll out of Individual Placement and Support (IPS)
- See chapters 3 and 6 for local action.

Improve air quality and respiratory health

- London wide work on air pollution is underway through a number of initiatives such as the introduction of the ultra-low emission zone.
- Improve access to respiratory services including asthma care for all ages early intervention and preventative work.
- NHS organisations to reduce business travel and unnecessary vehicle trips to hospital for patients.
- The London Respiratory Clinical Network aims to support primary care networks (PCNs) to have integrated one stop diagnostic hubs for respiratory disease and increase virtual registry reviews.
- See chapter 5 for local action.

Improving sexual health and eliminating HIV

- Reach zero new HIV infections.
- Chapter 5 includes further details on this for north east London, and outlines an example of cross-system work to transform our local sexual health service provision.

Healthy living

- Collaborative work on a London food strategy
- Promote physical activity through the Healthy Streets initiative
- Collaborative work on alcohol, tobacco and drugs is underway at the London level.
- For local action on prevention see chapter 3.

Improve the health of homeless people

- Better access to and improving specialist mental health support for homeless people. The Mayor has developed a rough sleeping plan of action and homeless health commissioning guidance has been developed.
- For local action see chapter 5.

Reduce the prevalence and impact of violence

- Reduce the impact of violence on younger people is a London-wide priority, but it is recognised that this will be delivered largely through ongoing action at a local level. In north east London this is a particular issue, and we outline local action in chapter 5.

Improve the mental health of Londoners/healthy minds

- Support good mental health and rapid access to high quality mental health care when people need it.
- Thrive LDN's Employment Network is developing a prevention initiative on healthier workplace cultures in the NHS.
- Thrive LDN also supports work on multi-agency suicide prevention strategies for a "zero suicide city".
- Further roll out the "Good Thinking" campaign to all local authorities and NHS organisations in London. Providing joined-up, seamless care, and ensuring that inpatient beds are in the right place.
- See chapter 5 for local action.

Improve the quality of life for ageing Londoners, addressing frailty and dementia, and improving care and support at the end of life

- Work towards a dementia friendly capital city.
- The London Frailty network focuses on enabling those living with frailty to get the care and support they need to lead as healthy, active and meaningful a life as possible. Whilst the London Dementia Clinical Network is focusing on raising diagnosis rates so that people living with dementia can access the support they need.
- Increasing the proportion of Londoners who die in a place of their choosing is a key focus for the End of Life Clinical Network.
- For local action on delivering the "Age Well" agenda see chapter 5.

There are also a range of London-wide ambitions relating to long-term conditions that we have outlined in chapter 5 of this Plan.

Summary

- Our ambition is for NEL to become an Integrated Care System by April 2021. This will be underpinned by one NEL CCG, three local systems: City and Hackney, BHR and WEL, our eight places (local authorities) and our 47 Primary Care Networks.
- Local accountability is at the heart of our ICS development with the intention that decision making should sit as close to local people as possible.
- Over the next few months we will be developing our approach to an ICS with the intention to start operating as a shadow ICS from April 2020.
- Engaging and involving our local populations will be at the heart of our ICS development.
- The most important feature of our ICS is our three distinct population-focused systems: Barking and Dagenham, Havering and Redbridge (BHR), Waltham Forest, Tower Hamlets and Newham (WEL) and City of London and Hackney.
- The BHR system is a collaboration between health and care commissioners and providers who have a strong history of working together. NELFT and BHRUT work closely together and share a Chair.
- Since 2016 the City and Hackney health and care system have been collaborating through the local integrated commissioning and care programme. Local co-production is at the heart of the City and Hackney approach.
- As a system Waltham Forest, Tower Hamlets and Newham operate strong place based partnerships through Tower Hamlets Together, Newham Wellbeing Partnership and Better Care Together Waltham Forest.
- Collectively we will work with other ICSs across London to deliver the shared ambition of making London the world's healthiest global city, working with our partners to deliver a number of priorities.

CHAPTER 3 - PREVENTION

Our prevention priorities

- Reduce childhood obesity
- Create healthy environments
- Improve Air Quality and respiratory health
- Healthy Living
- Improve the mental health of Londoners
- Address tobacco, alcohol and drug use
- Support homeless and rough sleepers

North east London context

North east London is an area that includes some of the most deprived neighbourhoods in the country. The relationship between deprivation and the risk factors for poor health outlined in the prevention chapter of the Long Term Plan means that addressing these factors has to be integral to addressing health inequalities.

The NHS cannot do this alone, but it needs to play its part. Addressing these issues, and those of the global burden of disease, will need concerted action at all levels with partners including the local authorities and non-statutory sectors such as the voluntary sector, housing associations, social enterprise and commercial sectors.

This is because sustained impact requires addressing the environmental, social, economic and cultural factors that powerfully influence the conditions in which people can live healthy lives as well as action at individual level.

However, prevention needs to be an integral principle of the health and care system in north east London as it helps us keep people healthy, identify conditions early and improve the outcomes of people living with health conditions. Manging prevention will help us to better manage demand for services.

Our prevention programme

Prevention is the backbone to the wider health and care system across London and an integral part of the London vision, which focuses on partnership working in order to address London's biggest health challenges. In north east London supporting people to better care for and manage their own and their family's general health and wellbeing is imperative if we want to alleviate further pressures and wider health deterioration as our population continues to grow and people's health needs become more complex. We believe that by working in collaboration with or partners to promote good health through prevention and improvement of avoidable illness, alongside supporting more personalised care we will deliver better health and wellbeing outcomes for our residents.

Across London partners from health and care have been working together to ensure children have a healthy start in life, to encourage residents to be fitter and healthier, to make work a healthy place to be, to support Londoners to kick unhealthy habits and ensure people are supported to look after themselves. At a NEL level partners, including the public, have been coming together to develop, agree and deliver a comprehensive plan which accurately reflects the vision for improved health and care across NEL through all stakeholders and local communities.

Place-based prevention

Prevention is a priority for all eight Health and Wellbeing Boards. In addition, all local authorities discharge their public health function through a range of healthy early years, healthy childhood, sexual health, substance misuse, healthy adult (e.g. tobacco, obesity,

physical activity, and health checks) and community development prevention programmes. These programmes all have common elements but will also vary according local need and resources. They all involve significant partnership work at Network, borough and local system levels.

Our NEL Prevention Board represents public health and other system stakeholders from across our area and leads the work of our prevention programme. This plan also takes account of the unique needs and make up of our local communities and future developments within the NEL system. Whilst we share many health challenges with other parts of the capital, but given the unique and complex demographics of our local populations, we have some specific prevention priorities.

The priorities for action identified by the group align closely with those set out in the Long Term Plan's aspirations on prevention. They have been agreed on the basis that through collaboration they strengthen and add value to existing borough based public health work (e.g. through economies of scale, alignment of approach, funding opportunities). On this basis, our priorities are smoking cessation, diabetes, social prescribing and screening.

Prevention priorities also run through our other programmes, such as cancer (screening and HPV), maternity (smoking in pregnancy), children and young people (immunisation, childhood obesity), primary care (diabetes, social prescribing) and urgent care (HIV screening in A&E).

Reducing childhood obesity
Around one in five of north east London's 4-5 year olds are an unhealthy weight. By the time they leave primary school aged 10-11 the proportion affected rises to two in five. In some boroughs up to 50% of children are affected as they head into secondary school.

Childhood obesity impacts on many other short and long term health problems from dental decay, liver disease and diabetes to heart disease, stroke and cancers. Lifetime healthcare and productivity costs of childhood obesity are estimated to be £130k per child.

Our high streets are flooded with unhealthy, cheap food (London has over 8,563 takeaway outlets (92.7 per 100,000 of the population)). Children living in poorer boroughs are surrounded by a significantly higher number of fast-food outlets.

The London vision and the Mayor's Health Inequalities Strategy (HIS) both set out London-wide actions including expanding the junk food advertising ban in more boroughs and NHS sites and partnering with TfL to increase the proportion of Londoners achieving two ten-minute periods of walking or cycling each day.

We want all children to have a fair chance at growing up healthy in London. The Mayor of London has made this a priority in his health inequalities strategy.
London has committed to a 10 per cent reduction in the proportion of children in reception (age 4/5) who are overweight by 2023/24 with action targeted on the most at risk and North East London needs to play its part in contributing to this aspiration.

All our Councils have plans addressing childhood obesity. Several boroughs support and are impacted on by London wide initiatives including the Healthier Catering Commitment, School Superzones, Play Streets, adoption of the Transport for London Healthy Streets approach and advertising restrictions of unhealthy food across the Transport for London estate. We are now prioritising implementing the findings and recommendations of the London Childhood Obesity Taskforce (by February 2020).

Immunisations

We are currently in the process of working across north east London to develop local action plans in partnership with all stakeholders to support the implementation of the UK Measles and Rubella Elimination Strategy. The strategy frames recommendations under four key areas that have been set out by the World Health Organisation (Europe):

- Achieve and sustain ≥95% coverage with two doses of MMR vaccine in the routine childhood programme (5 year olds)
- Achieve ≥95% coverage with two doses of MMR vaccine in older age cohorts through opportunistic and targeted catch-up (>5 year olds)
- Strengthen measles and rubella surveillance through rigorous case investigation and testing ≥80% of all suspected cases
- Ensure easy access to high quality, evidence-based information for health professionals and the public.

Directors of Public Health are working closely on all aspects of immunisation including seasonal influenza and HPV, and we will have a more detailed local action plan outlined in the final draft of this document.

Improving air quality and respiratory health

Like London as whole, the quality of air in many areas within NEL is dangerous to health and breaches legal limits.

Our schools are often surrounded by poor air quality with 1 in 5 primary schools in poor air quality areas. This is a London wide priority with work on air pollution underway through a number of initiatives such as the introduction of the Ultra Low Emission Zone (ULEZ). The focus is on improving access to respiratory services including asthma care for all ages, early intervention and preventative work as well as supporting NHS organisations to reduce business travel and unnecessary vehicle trips to hospital for patients. The London Respiratory Clinical Network aims to support Primary Care Networks (PCNs) to have integrated, one stop diagnostic hubs for respiratory disease and to increase virtual registry reviews.

We want people in north east London to breathe clean air. This will require coordinated action across the whole system strengthening air quality management. We will play a lead role in reducing emissions and exposure to pollution, particularly in relation to vehicle fleets. In addition, we will need to raise awareness amongst the public of what they can do to reduce their contribution to poor air quality and improve their health through increased active travel.

All NEL boroughs have air quality plans. The next priority for the NEL Prevention Group is to review borough level air quality plans (by March 2020). Specific areas of focus over the next 3 years will be expansion in electric vehicle infrastructure, expansion of the Low Emission Zone to the North Circular and NHS commitments to cut business mileage and fleet air pollutant emissions by 20% by 2023/4.

Improve the mental health of Londoners/ Healthy Minds

One in four people across NEL experience mental ill health every year. The impact of mental health does not however have an even distribution. Those experiencing poverty and deprivation are disproportionally affected by poor mental health. Supporting good mental health and rapid access to high quality mental health care is a London priority. Thrive LDN's Employment Network is developing a prevention initiative on healthier workplace cultures in the NHS. Thrive LDN also supports work on multi-agency suicide prevention strategies for a "zero suicide city". There is also London wide support to further roll out the "Good Thinking" campaign to all LA and NHS organisations in London. Providing joined-up, seamless care, and ensuring that inpatient beds are in the right place is also a London wide priority.

All of NEL is involved in a range of Thrive London programmes including working with communities to support mental wellbeing, mental health first aid and suicide prevention training. They are also contributors to the Good Thinking programme (a digital mental health and wellbeing service for adults) and all NEL boroughs currently have suicide prevention plans. In alignment with the aspiration for London to become the world's healthiest global city (The Mayor's London Vision), our vision for north east London is to be a place where everyone's mental health and wellbeing is supported. The next steps for the NEL Prevention Group include the review of our borough level work and engagement with Thrive London, the Good Thinking campaign as well as our suicide prevention plans in collaboration with the dedicated NEL Mental Health programme; assessing the opportunities for NEL wide alignment and reduced variation of care (by March 2020).

Reducing smoking
Smoking remains north east London's leading cause of premature death. It contributes to four out of the five most common health conditions that kill Londoners. We will play our part in London becoming the first global smoke free city (defined as less than 5% prevalence).

This means:

- children will get the best start in life as their parents get effective support to stop smoking in pregnancy
- the services that parents and carers are in contact with via early years provide access for parents to the best possible support to help them stop smoking
- ensure infants and children are not exposed to second hand smoke in any of the environments they experience as they grow up (home, early years settings, schools, youth services, public spaces) nor any experiences where smoking is seen as a positive habit (e.g. role modelling, commercial promotion)
- children and adolescents are not enticed into starting smoking at a young age by easy access to low cost illegal tobacco which both starts a lifelong habit.
- adult smokers live and work in a 'smoke free' environment in which not smoking is the easier option (e.g. public spaces, schools, parks, hospitals). In particular we want to introduce the Ottawa model for smoking cessation and build on work already underway such as Stop Smoking London.
- smokers and users of other forms of tobacco have access to a range of options that:
    - work for their lifestyles (face to face support, phone/text support, digital support)
    - are marketed to them based on insight into their preferences
    - are provided across the settings in which they live their lives (e.g. digital platforms, media, workplaces, health and care settings, public spaces)
- All NHS settings are exemplars of 'smoke free' organisations

All our Councils have plans to address tobacco use, encompassing a range of interventions included specialist stop smoking services (universal and/or targeted), education in schools, stop tobacco campaigns (including oral tobacco, shisha as well as cigarettes) smoke free organisations (e.g. NHS, council, workplace) and enforcement activity (e.g. illegal tobacco, underage sales). We are now working collectively to set out a clear plan for implementation of the Ottawa Model by March 2020.

Reducing harm from alcohol
In north east London, health and care partners actively work together to contribute to licensing decisions which take account of public health intelligence around alcohol harms whilst supporting a vibrant night time economy. We will take action to minimise the impact of alcohol on the most vulnerable in our communities including the children of dependent and harmful drinkers and will work in partnership to increase the number of dependent drinkers

receiving treatment and ensure we establish well-resourced Alcohol Care Teams for every hospital in the area.

Reducing harm from drugs
Across NEL we need to look at the different types of drugs, both legal and illegal, people's reasons for using them and the effect they have on mental health, lifestyle and general wellbeing. Drug use and associated violent crime is complex and cannot be tackled by one agency alone and we support multi-agency approaches to reduce harm. Clearly, there is a link between crime and drug use and we support referral into treatment to break the cycle of offending. People in treatment use fewer illegal drugs, commit less crime, improve their health and manage their lives better. Keeping people in treatment long enough to benefit contributes to better outcomes for the person and the wider community.

Reducing violent crime
Violent crime destroys lives. As a partnership, we need to do more to tackle knife crime in north east London. The number of stabbing victims with life-threatening injuries treated by specialist trauma doctors has increased significantly, with an increase in the severity of attacks.

Keeping children and young people safe is everyone's responsibility. We will look at how we can use the London Mayor's violence reduction unit which brings the police together with specialists from health, local government, probation and community organisations to tackle violent crime and the underlying causes of violent crime, taking a public health approach. We will explore placing youth workers in A&E departments, to help steer our younger people who have been involved in knife crime away from violence in the future.

Addressing gambling addiction
There are an estimated 430,000 people in the UK with a gambling problem. There is an increasing link between problem gambling and stress, depression and other mental health problems and we will explore how we can address this, working together across NEL.

Tackling homelessness
The Mayor of London and the Ministry of Housing, Communities and Local Government are funding a two-year pilot, specialist service across NEL with ELFT and NELFT. In each area, this will include a dedicated team of mental health practitioners working with people sleeping rough and homelessness outreach teams, accompanied by initiatives to improve learning and collaboration between the mental health and homelessness sectors.

There were 238 rough sleepers recorded across NEL in 2018/19 (LHF Atlas data) with the highest concentration located toward the central boroughs. More than half of people sleeping rough in London are recorded as having a mental health need, but it can be difficult for them to access mental health services. Homelessness outreach teams will work with the new teams to identify people sleeping rough who may have mental health issues and are in need of support or treatment.

Through this, the programme will:

- develop an improved understanding of the needs of people with mental health needs who are sleeping rough; and
- enable services to try out new ways to make their services more appropriate and accessible for people with mental health needs who are sleeping rough, meaning people with mental health needs who are sleeping rough will experience better health and accommodation outcomes.

People sleeping rough who have mental health issues will receive flexible, personalised and relationship-focus support. The learning and collaboration aspects of the programme will

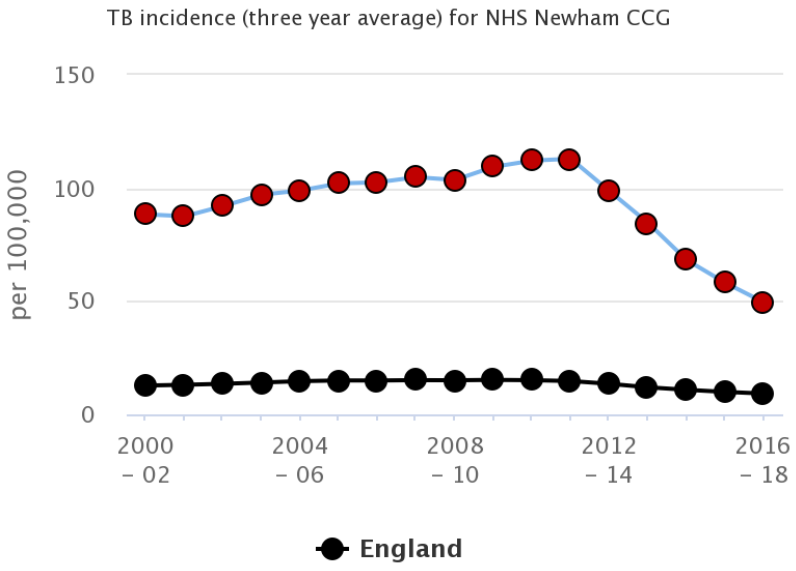
increase understanding of the needs of this population across both the mental health and homelessness sectors and develop how these two spheres work together to improve outcomes.

Locally, NELFT and ELFT have co-developed a local service in our area in partnership with the local homelessness outreach teams and borough rough sleeping commissioners. There are a range of good practice examples in parts of NEL currently including specialist primary care provision, mental health outreach and the 'Pathway' service at the Royal London which was introduced in 2011 to provide specialist support for homeless people presenting in A&E. The multi-disciplinary approach includes GP and nurse time plus links to a social worker and housing team. The team deal with around 900 admissions of homeless people per year.

We are keen to work together to improve the health and care of people who sleep rough to improve quality and access as well as enabling smoother transitions across services. We can help identify gaps and determine where current local good practice could be extended; help develop more collaborative pathways across boroughs and healthcare providers; help make the help available, whether that be substance misuse or mental health support, consistent across boroughs; and help standardise assessment timescales. Our aim is to stop some of the most vulnerable people in our population from slipping through the net or being passed around the system.

Tuberculosis (TB)
There is a national ambition to bring best clinical practice to improve TB control and see a year on year decline of incidence, with the ultimate intention to eradicate this disease in England. The 2020 ambition remains and work continues to embed process in NEL.

Our ambition is to standardise case finding throughout the NEL system to improve detection and testing rates in order to meet the NHSE ambition. Currently TB incidence is declining across all NEL CCG areas and the aim over the coming weeks is to identify ways to continue this improvement and meet the NHSE ambition. With some significant work in Newham CCG which culminated in a HSJ award for 'Community and Primary Care Service Redesign' for its approach to tackling this condition. As seen below the marked decline in Newham shows a step change and something which others across the sector will consider how best to meet the need to eliminate this preventable disease.



HIV

In 2018 337 people were diagnosed with HIV in NEL. There is a need to ensure that HIV health outcomes, HIV prevention, testing and treatment are effective and integrated with wider healthcare meeting the needs of people living with or at risk of acquiring HIV in the capital. HIV is now considered a long term condition and this still requires further engagement and consideration to ensure increased awareness of this status (see chapter 5).

NEL boroughs are participants in the London HIV Prevention programme (working with partners to deliver sexual health promotion outreach to men who have sex with men, and a free condom distribution scheme across more than sixty venues in the capital. In addition, several boroughs commission local programmes promoting prevention and early identification of HIV as well as support for people living with HIV (targeted at high risk groups including men who have sex with men and Black African). As part of the London aspiration to reach no new HIV infections by 2030, we are committed to taking forward across NEL the priorities of the Fast Track Cities Initiatives around identifying and supporting undiagnosed HIV, addressing stigma, delivering a HIV prevention programme and use learning from HIV to help diagnose and treat other blood borne viruses including hepatitis C and sexually transmitted diseases including chlamydia, gonorrhoea and syphilis.

Moving forward the NEL prevention group is to review progress on HIV testing in A&E (this is in the process of being implemented) and to review collaboration and implementation of the four key London HIV priorities as indicated by people living with HIV (PLWH) in London (see chapter 5).

Behaviour change

Behaviour plays an important role in people's health (for example, smoking, poor diet, lack of exercise and sexual risk-taking can cause a large number of health conditions/diseases). Interventions to change behaviour have enormous potential to alter current patterns of disease and improve health.

Actions to bring about behaviour change may be delivered at individual, household, community or population levels using a variety of means or techniques. The outcomes do not necessarily occur at the same level as the intervention itself. For example, population-level interventions may affect individuals, and community- and family-level interventions may affect whole populations.

The partnership will explore a coherent and evidence-based approach, considering generic principles for changing people's health-related knowledge, attitudes and behaviour, at individual, community and population levels.

Spotlight on: City and Hackney's Prevention Investment Standard

A clear commitment has been signalled to increase the focus on, and investment in, ill-health prevention in City and Hackney.

The Prevention Investment Standard is our commitment to increase spend on prevention activities at a faster rate than general health budgets. Over time this will drive a shift in resource and focus towards preventative activities and away from reactive activities.

The investment standard will be supplemented by funds to invest in community services to pilot new prevention activities; and to invest in prevention activity in provider services, with a top-slice of existing budget reserved for prevention activities.

The next step is to set priorities for investing in community and provider services, with the potential to improve people's long-term health and wellbeing, address health inequalities and achieve financial sustainability.

The London vision

All partners in our system are fully committed to the London Mayor's Vision to make London the healthiest global city, and the best global city in which to receive health and care services. Like many big cities, London offers a wealth of opportunities for people to lead healthy and happy lives, but it also presents issues and challenges to health. In London, where there are significant and persistent inequalities, these issues and challenges are experienced most by those in our most deprived neighbourhoods and communities. That is why concerted and coordinated efforts are needed across public services and wider society to make the most of opportunities for good health, and to tackle the issues that cause poor health.

Building on significant work between our organisations over several years, our London Vision sets out our proposals for the next phase of our joint-working. It reflects the Mayor's Health Inequalities Strategy, London Councils' Pledges to Londoners, the Prevention Green Paper and the NHS Long Term Plan. It highlights ten key areas of focus where we believe partnership action is needed at a pan-London level. This includes issues such as air quality, mental health and child obesity, and we set out our ambition for deeper and stronger local collaboration in neighbourhoods, boroughs and sub-regional systems so that services are genuinely integrated, and Londoners can start well, live well and age well. Our Vision is not a description of the multitude of actions that are taking place locally, nor a population health plan, rather it sets out the areas where our shared endeavours seek to complement and add value to local action.

Areas of focus for pan-London working: summary of commitments

Area of Focus	Commitments (in the London Vision)
Reduce childhood obesity	• We will achieve a 10% reduction in the proportion of children in reception (age four or five) who are overweight by 2023/24, delivered through bold citywide actions and targeted support for those most at risk
Improve the emotional wellbeing of children and young people	• We will ensure access to high quality mental health support for all children in the places they need it, starting with 41 Mental Health Support Teams in schools, maximising the contribution of the Mayor's/GLA's Healthy Schools London Programme and Healthy Early Years London Programme, and extending the use of digital support technologies.
Improve mental health and progress towards zero suicides	• We will ensure that all Londoners have access to mental health care, support and treatment, especially those experiencing health inequalities
Improve air quality	• We work together to reach legal concentration limits of Nitrogen Dioxide (NO_2) and working towards WHO limits for particulate matter$_{2.5}$ concentrations by 2030.
Improve tobacco control and reduce smoking	• We will speed up a reduction in smoking prevalence in London, especially among groups with the greatest health inequalities
Reduce the prevalence and impact of violence	• We will work collaboratively with the London Violence Reduction Unit to develop and implement effective ways of reducing violence, including addressing its root causes

Improve the health of homeless people	• We commit to drive action to improve, grow and innovate services that improve the health of rough sleepers, including expanding the pan-London rough sleeping services funded by the Mayor, building on existing good practice, piloting new models of care and data collection, and developing plans to build more integrated services in London
Improve services and prevention for HIV and other STIs	• We will broaden partnership working to focus further on tackling health inequality and a wider range of sexually transmitted diseases
Support Londoners with dementia to live well	• We will ensure that Londoners receive a timely diagnosis, ongoing support and are able to live well in their community
Improving care and support at the end of life	• We will ensure that all Londoners in their last year of life have access to personalised care planning and support that enables them to die in their preferred place

	People, places and partnerships to support wellbeing and self-care	Integration to provide joined-up community based services	Collaboration to sustain high quality specialist networks
 Start well	Our environment, schools and communities promote and nurture the health and wellbeing of all children and families	Schools and health and care services work together to provide a seamless service and give families and children tools to manage their own health	Children and young people have access to high quality specialist care, with safe and supported transitions to adult services
 Live well	Our environments and local communities help us avoid unhealthy habits and eliminate homelessness and any stigma surrounding mental health	Early support for health issues is consistently available and there is true parity of esteem between physical and mental health	Londoner's have access to high quality 24/7 emergency mental and physical health, alongside world-class planned and specialist care services
 Age well	Londoners are supported to manage their long term conditions and maintain independence in their community	As people grow older they are supported in their community with seamless care between organisations	Hospital care is consistent, of high quality and safe and ensures Londoner's can get in and out of hospital as fast as they can

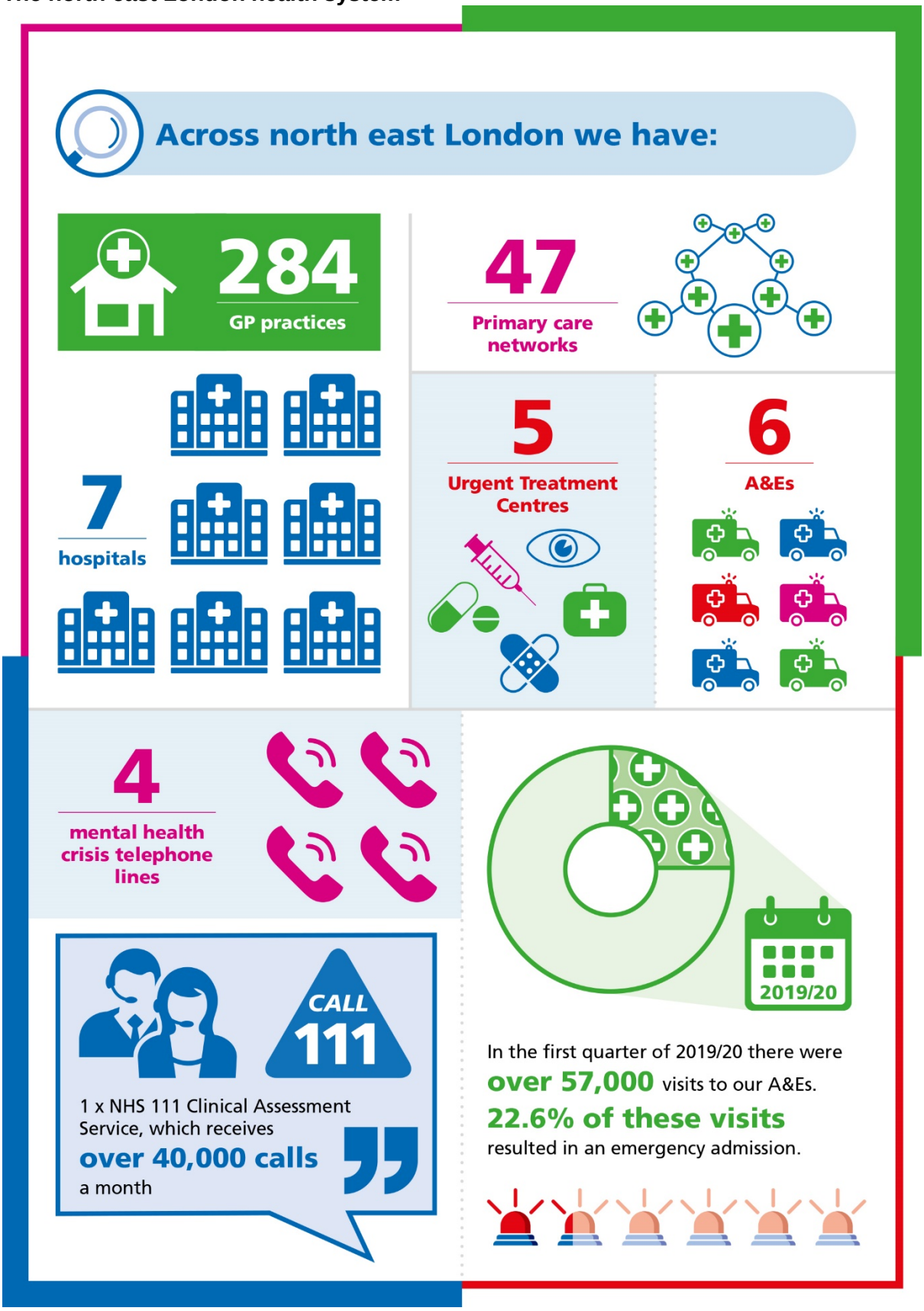
Enabled by: Ensuring Londoners are **engaged in their own health** | Digitally connecting London's **health and care providers** | Developing **London's workforce** | Transforming **London's estate**

Summary

- We are committed to the Mayor London's Vision to make London the healthiest global city.
- Improving our approach to prevention is an integral part of our ambitions to transform the health and care system in north east London.
- Working with partners we will ensure children have a healthy start in life and we will encourage local people to live healthy, active lives.
- Our NEL Prevention Board brings together public health and other system leads to focus on the following priorities: reducing childhood obesity, improving air quality and respiratory health, improving the mental health of Londoners/Healthy Minds, Smoking cessation, alcohol and drug misuse, violent crime, gambling, homelessness, HIV and behaviour change
- Across each priority we are seeing improvements but there is still more to do and we will use the development of our ICS and implementation of this Plan to build on our work to date and ensure prevention is at the heart of what we do.

CHAPTER 4 – DELIVERING CARE FOR THE 21ST CENTURY

The north east London health system



Clinical strategy

The north east London clinical senate has led the development of this refresh of our strategic plans as an STP. We have had specific senate sessions looking at the key national Long Term Plan delivery areas from a north east London perspective, which shaped how we have developed this draft SDP. Each of our ELHCP work programmes has a designated senior clinical lead from across the system, and each has been reviewed by the senate over the last six months. We have also had specific discussions on the clinical service areas such as neuro-rehabilitation services and the use of mechanical thrombectomy for acute ischemic stroke. On top of this we have organised clinical challenge sessions on the development of the new Whipps Cross, the BHR System Clinical Strategy, and the NEL primary care strategy.

We have also recently reviewed the membership of the senate, ensuring that we reflect each of the developing local systems in its membership and reflecting a wider range of clinicians (nurses and allied health professionals in particular). During the autumn we will be implementing proposals to have a specific Nursing and AHP Clinical Cabinet for north east London, which will work specifically to support the senate and our workforce delivery programme. Our Darzi Fellows also attend the senate, providing specific primary care input, and we have regular feedback both from and to the London-wide clinical networks. Directors of public health are also active members of the senate, and we have also discussed and agreed the London Vision at the most recent of our senate meetings.

Reshaping surgical and clinical services in north east London

Across north east London many challenges exist with respect to clinical and surgical services, and these will form the basis of cases for change and specific system strategies being developed. These challenges exhibit related themes covering areas such as the expected population growth, workforce limitations, variable performance against key waiting time targets, capacity and estate utilisation, quality and efficiency improvement needs and financial pressures. There is recognition and acknowledgement across providers that there is a need to better understand not only single organisational capacity challenges, but also those across NEL services where we anticipate that there will be greatest capacity challenges in the future. These pressures alongside the evolution toward greater integrated and personalised care highlight the need to better connect and consolidate certain clinical services across organisations to ensure resilience and sustainability, and to utilise digital solutions, research and innovation fully.

Any proposals for the future of services are being, and will be, developed with service users, carers, families, residents and their representatives. There is commitment to making sure that the rationale behind any changes is explained clearly, that any proposed changes will be subject to public engagement and formal consultation as and when appropriate, and that decision-making processes are transparent. Integral to developing the clinical strategy is always our clinical senate, whose role is to ensure that all programmes and plans that are developed are safe, effective and that the reasons underpinning activity and financial assumptions are clinically sound. They also have an active role in horizon scanning, and considering new clinical developments and how we can embed these across our system for the benefit of patients and staff.

Case study: BHRUT virtual fracture clinic

A pilot project at Barking, Havering and Redbridge University Hospitals NHS Trust is reducing the number of patients who need to attend fracture clinics.

The Virtual Fracture Clinic enables patients' scans to be shared electronically between the teams in Urgent Treatment Centres. This means consultants looking after patients referred from the UTCs are able to make a decision on their condition, and the most appropriate treatment, without seeing them face-to-face.

The idea emerged from an event involving BHRUT staff, patient representatives and other stakeholders as part of the trust's Outpatients Transformation programme.

The first challenge was improving communication between clinical teams. A lot of work was required to ensure IT systems could support the project and that information governance regulations were met.

As well as reducing the number of patients seen in fracture clinics, the virtual clinic also helps identify patients who can safely be discharged. It is planned to expand the team by two trauma and orthopaedics consultants and open the virtual clinics to UTC clinicians to support their training and improve future referrals.

There are also plans to extend the virtual clinic concept to other specialties and to open virtual clinics at the walk-in centres in the BHR system.

Our key strategic clinical challenges

Prevention across the system

In line with the national direction we are encouraging a shift toward prevention across all parts of the system as detailed within sections covering prevention and long term conditions. For example the clinical Senate has and will continue to support the establishment of NEL wide CVD, stroke and respiratory groups that will have core elements based on the prevention of disease. The primary outcome of improving the local health and wellbeing of the population will also translate into combating the challenges by reducing pressure and demand on services.

System integration and care closer to home

Across the NEL system the improvement of integration between organisations has begun to develop. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), which runs Queen's and King George hospitals, is developing its clinical strategy which will detail what hospital services will look like in years to come, helping to ensure the continued provision of high quality care for local people. Production of the BHRUT strategy is being led by clinicians and staff at the Trust, working closely alongside partners including GPs and local councils. Though there are some areas which are not up for consideration, for example the Trust will keep a Type 1 Emergency Department at both hospitals.

Priorities identified within the BHRUT strategy aim to tackle some of the wider NEL challenges by improving integration and collaboration.

- Develop joined-up teams of health and care professionals (doctors, nurses, therapists, social workers) to proactively care for patients with complex needs (for

example people with more than one long term condition) helping them stay as well as possible and prevent avoidable admissions to hospital. Work with other NHS and care organisations in our area to identify which patients will most benefit from support from multi-disciplinary teams of health and care workers, deciphering how best to organise and provide care. Put in place the necessary systems and processes that will allow professionals to work together even if they come from different organisations. For example, having the right IT systems, ensuring information can be shared but remain safe and confidential, ensuring that everyone is working to the same quality standards etc.

- Maximise the opportunities presented by digital and remote technologies to work more efficiently and to offer alternative and easier access to care. Replace or update any old computer systems that are inefficient or have a significant negative impact on patient experience. Work towards establishing joined up patient care records with other organisations to improve joined-up working and deliver better quality care. Explore opportunities to use technology to make us more efficient and offer improved access to

- Ease of access to the most appropriate urgent or emergency care service. Ensuring that the local population are able to access urgent and emergency care when they need to, and are seen in the most appropriate place for their needs; making the most of our urgent treatment centres and same day emergency care services.

- Reducing the variation in quality of care ensuring the best use of capacity and resources by consolidating some services on to fewer sites and developing centres of expertise (and maintain a Type 1 Emergency Department at each hospital). Review where we can strengthen services making them sustainable by analysing the multi-site services and considering the evidence indicating where creating centres of expertise would benefit patient care. This would need to include a review and redesign regards ways of working to ensure consistency of care when services are provided across sites.

- Redesign outpatient services to make best use of available workforce capacity and resource. Assess where we can change and improve our ways of working so that patients get the right care and appropriate follow-up in a place that makes the most sense for patients and for local NHS care organisations.

- Transfer specific services into the community or the Goodmayes site. Review services which need not be hospital site based in order to release space at Queen's and King George hospitals for care that does require hospital provision. Assessment of those services being transferred out of hospital will consider the skills and equipment needed to deliver the service elsewhere ensuring the most appropriate alternative sites for care.

- Redesign how planned care (operations and treatments that are booked in advance) is organised to make best use of available capacity and resources with an ambition to becoming the provider of choice (versus private providers). Utilising best practice guidelines and standards e.g. Getting it Right First Time (GIRFT), to redesign planned care so that it is as safe and efficient as possible. Review which types of surgery and treatment patients receive in a private hospital, that could be better delivered by our hospitals and would increase funding for the Trust. Review what factors influence where patients are referred for planned treatment so we can understand how to bring more planned care to BHRUT. Explore opportunities to improve our capacity so we can provide more planned care.

- Develop into an employer of choice by partnering with NHS organisations, and academic institutions (universities and colleges) to make BHRUT a more attractive place to work, and strengthen our workforce. Explore the potential for joint training, secondment and academic opportunities with other NHS organisations.

- Build partnerships with NEL organisations to provide specialised care. There are some areas of specialised care that are provided to a small number of patients that NHS regulators are encouraging trusts to work together to provide. Working with partners such as Barts Health to build on strengths will allow the delivery of efficient specialist services for local populations.

- Work with NEL NHS partners to develop sustainable maternity and paediatric (children's) services, in the context of a growing population. BHRUT are one of the largest single site maternity services in the country. Therefore proactive coordination and collaboration with NEL partner organisations will ensure continued provision of high-quality and adaptable services able to cope with the changes in demand.

Clinical integration

Greater integration is also being progressed via the WEL out of hospital services strategy, bringing together Tower Hamlets, Waltham Forest and Newham. This will involve working under one common and shared model where appropriate, whilst concurrently sharing lessons learnt. For example this will cover developing and implementing a common model for outpatients, urgent care and MSK as detailed in chapter 2. Another related development intended to lead to enhanced integrated care is the increasingly closer alliance of BHRUT and NELFT, driven by the aim of exploring how best high quality and sustainable care can be delivered across BHR for people living with increasingly complex long term conditions. Clinical discussions on expanding integration across mental health and community services is also detailed in chapter 2.

Neuro-rehabilitation is also an area where further integration and the location of care closer to home will be transformed. Traumatic brain injury is responsible for around 900,000 A&E attendances, and over 200,000 hospital admissions per year in England and surviving patients face a multiplicity of physical, cognitive, emotional and behavioural problems. These problems are compounded by a lack of access to appropriate rehabilitation. At present the management of this clinically complex patient group is fragmented and variable, and associated with poor outcomes. Clinical leads across Homerton and Barts Health have been reviewing the latest research and evidence to define an optimal neuro-rehabilitation pathway with collaboration with BHRUT to evolve as a clearer strategy develops.

Currently there are two linked proposals that will support a new optimal pathway, these are being developed for consideration by specialised (NHSE) and local commissioners (CCGs):

1. A new model of care to introduce early neuro-rehabilitation through a Rapid Access Rehabilitation Unit at the bedside for the most critically ill patients while still in the care of the major trauma centre at the Royal London.
2. A proposal to increase access to neuro-rehabilitation for other patients both within hospital (at the Homerton) and in the community through the development of new local services, with the potential to improve patient outcomes and reduce long-term care needs for some patients.

Clinical teams are aiming to improve practice by reassigning responsibility to an 'expert leader' to ensure that admitted patients and outpatients become, and continue to be, primarily the responsibility of a specialist consultant-led interdisciplinary team.

The approach is aimed to:

- Improve patient flows and outcomes.

- Increase cohesion of the care pathway.
- Reduce the cost of preventable disability and length of stay in acute beds.
- Avoid disruption of the overall function of the trauma service.
- Release acute neurosurgical beds for other patients in need.
- Reduce long term disability and care needs, including CHC funded placements and local authority packages of care.
- Form a knowledge-based network that enables trials, research and the implementation of new treatments.

Centres of expertise

The aspiration we have is to encourage the development of centres of expertise which will improve quality, create a sustainable workforce and maximise research and innovation opportunities. In line with this the Barts Health surgical strategy aims to progress development towards providing outstanding surgical services for patients; the Trust's recent improved CQC ratings and exit from quality special measures provides an opportunity to take this forward.

There is excellence in Barts Health surgery, typically where surgery is concentrated in a high volume centre. However, a range of other surgical services are currently dispersed across a number of low volume centres and the workforce (and therefore the expertise) is also dissipated across Barts Health sites. This results in variable quality and outcomes such as long waiting lists. There are prospects for the hospitals to work more effectively together bringing treatments together into single centres (a principle endorsed in the Transforming Services Together programme in 2016).

Across north east London we already have centres of excellence in cancer, cardiac, trauma and stroke to bring care to patients in a way that gives best possible outcomes and are therefore considering the same approach in other areas.

Clinical leads believe the development of centres of specialist expertise should be at the core of the surgery strategy – creating higher volume centres where all the complex surgical activity is undertaken in one place, enabling improved quality of care and outcomes. They would also like to see the development of networks in some other pathways to improve access to specialist expertise and increase the resilience of 24/7 services.

Five opportunities for improvement in surgery have been identified:

1. Ensuring all patients are able to access the same high quality care.
2. Tackling the workforce challenges across sites. Staffing levels, experience and skill-mix will help us recruit, train and retain the staff we need to deliver exceptional care.
3. Developing a network approach in some pathways to enable more cross-site and cross-organisational working, thus improving access to expertise and resilience of services.
4. Embedding education and research into our clinical services to drive improvements in patient outcomes and staff development.
5. Aiming for our local NHS hospitals to be the first choice for patients in north east London and beyond for all relevant tertiary services.

Surgeons, working with national bodies providing guidance on best practice, have looked at the best ways to improve patient access, outcomes and experience and reduce cancellations of surgery, waiting times and the length of time patients have to stay in hospital. Surgical activity which could potentially be concentrated on one site:

- Whipps Cross Hospital could have a greater focus on surgery relevant to the care of the elderly. This is in line with the Trust’s aspiration that the hospital becomes

renowned for the integrated treatment and care of frail and older people; reflecting the proportionately larger older population of Waltham Forest.

- Newham University Hospital could host centres for routine day-case surgery and also specialist women's surgery. Expanding these services would absorb planned surgery from the Royal London and reduce the risk of routine operations being delayed by complex or emergency surgery.

- In addition to the major trauma centre, the Royal London Hospital could be developed into a centre of excellence for all complex, multi-specialty services, including a bespoke centre for the treatment of abdominal and pelvic conditions, and inpatient surgery for children and young people.

- St Bartholomew's would continue in its role as a world-leading provider of cardiac and thoracic surgery and a specialist cancer centre

- Alongside these surgery changes, the Trust would continue to develop community-based services at Mile End Hospital to create a diagnostic and walk-in medical hub, providing the majority of outpatient chronic pain procedures and cancer diagnostics.

These emerging hospital identities are not mutually exclusive. Whipps Cross and Newham would continue to serve their local communities as the first port of call for urgent and emergency care, as well as for many routine medical interventions. As an example, although Whipps Cross may develop a focus on care for elderly it would continue caring for (and operating on) children when needed. Also, as Newham developed a specialist identity as a day-case centre, surgeons on day duty would continue to perform general operations to support the emergency department.

Barts Health surgeons perform approximately 95,000 operations a year. The gradual transformation of the changes being considered would mean that in ten years' time a proportion of these operations would be undertaken in around a dozen new centres of excellence in hospitals rather than their current locations, At each hospital, some of the existing surgery activity would be located elsewhere in the group, while other activity would move in.

The Homerton also have a number of centres of excellence. Their neuro-rehabilitation service is a nationally recognised referral centre, and we are actively engaged in the process of redesigning it to continue to meet increased demand. The Neonatal Intensive Care Unit (NICU) at the Homerton is the largest in the country with 42 cots, and the Centre for the Study of Sexual Health and HIV is one of the leading academic and research centres for HIV in the country.

Networked hospital services

We need our hospitals to work more effectively together in networks to improve co-ordination, care quality making best use of our estate. For example Barts Health NHS Trust and Barking Havering and Redbridge University Hospitals NHS Trust have continued working over the last twelve months on co-operating in a number of clinical areas, most notably in neurosurgery, provision of mechanical thrombectomy services to stroke patients in North East London and the wider region and, lastly, vascular surgery.

The clinical neurosurgery teams at The Royal London and Queen's Hospital have been exploring collaborative working across a number of sub-specialities. Both hospitals could benefit from greater cooperation in regards providing improved services for the NEL population with respect to current consultant numbers and their large catchment areas. The

intention is to join resources to provide greater scale, specialisation across both hospitals and ensure patients access the appropriate infrastructure as necessary. The first area of collaboration is in brain cancer surgery where the teams now have a single, integrated multi-disciplinary team meeting in place and have also established a joint out-of-hours on call. Consideration is being given currently, in conjunction with NHS England, to organising new pathways between both hospitals for patients with particular surgical needs with a target to realise these changes early next year. This would be the first of a number of sub-speciality collaborations that will enhance both services and further improve care for patients.

The NHS in London has set itself the challenge of providing access 24/7 to mechanical thrombectomy services for stroke patients. Both The Royal London, Whitechapel and Queen's Hospital, Romford have large stroke services and have neuro interventional radiology teams offering thrombectomies during extended hours at the moment. Discussions are active on looking to combine the resources and on-call arrangements between teams to accelerate provision of 24/7 cover targeting establishing this at the end of the calendar year.

Finally, discussions between vascular surgical teams have started negotiations on providing mutual support following both departments recent visits by the Getting it Right First Time team at NHS England. Early proposals include concentring complex procedures, including aneurysms and carotids. Additionally, the teams are also anticipating a joint out-of-hours on call, which will not only provide better cover to vascular patients but also the complementary trauma and general surgery rotas at both hospitals.

Another networking opportunity for hospitals with benefits to wider health and care providers is the improved coordination of pathology across NEL. As required by NHS Improvement, we are working to establish a pathology network, to provide more responsive, high quality and efficient services, for north east London. Consolidating pathology services allows for the most consistent, clinically appropriate turnaround times, ensuring the right test is available at the right time. It also makes better use of our highly skilled workforce to deliver improved, earlier diagnostic services supporting better patient outcomes. Achieving these aims will require better use of technology (current and future) and utilisation of software in order that test results are accessible in a timely way across service providers e.g. community and primary care having immediate access to blood tests undertaken within an acute setting and vice versa.

Taking a hub and spoke approach to this consolidation can ensure an appropriate critical mass to support specialist diagnostics, so that patients have equal access to key tests and services are sustainable. The Homerton and Barts Health are working with Lewisham and Greenwich Trust to create a pathology network.

Homerton University Hospital Foundation Trust (HUHFT) are also integral to delivering a common strategy of surgical care across NEL. The HUHFT is an acute and community trust delivering care to the people of the City of London, the London Borough of Hackney and beyond. HUHFT has consistently met its access targets and achieved financial balance for a number of years. It is currently rated good by the CQC. The Trust actively supports a move to greater integration; supporting out-of-hospital care where this is best for patients, and continuing to deliver acute services where hospital care is required.

As well as important relationships in Hackney, with East London Foundation Trust, the GP Confederation and others, the Trust continues to develop clinical networks with specialist hospitals particularly with St Bartholomew's and the Royal London Hospitals. Ensuring that these relationships are effective means that local medical and surgical services can be delivered and only transferred when specialist intervention is required. The development of greater surgical and medical capacity on the Homerton site is important in continuing to meet

population growth and ensuring that community services are delivered around the neighbourhoods model (see chapter 4 for more detail).

Specialised commissioning

NHS England are currently accountable for direct commissioning of prescribed specialised services for patients seen at the five trusts within ELHCP. The combined annual contract value of these services is £718m, equivalent to approximately one-sixth of all commissioning spend within the NHS in north east London. The key services involved in these contracts include:

- Acute cardiology
- Cancer services, including chemotherapy
- Neonatal care at all three acute Trusts
- Renal services
- Neuro-surgery and neuro-rehabilitation
- HIV
- Sickle cell and Thalassemia
- Medium secure psychiatry
- Children's inpatient mental health
- Perinatal psychiatry

These services typically provide care to patients from a wide geographical area, including Essex and west Hertfordshire in some cases, and have traditionally seen increases in costs and demand higher than for CCG commissioned services linked to new drugs and devices and increased patient acuity. The separation of NHS commissioning between NHS England and CCGs has in some cases led to poor design of care pathways, e.g. by removing the link between investment in primary care and prevention from changes in demand for highly acute services. The ELHCP are therefore establishing plans to increasingly localize planning of these services partly through joint or delegated commissioning and partly through provider-led delivery networks, giving local clinicians greater control over resources and the re-design of care pathways to improve quality and patient satisfaction.

The service areas identified for piloting of STP and CCG led commissioning from 2020/21 are as follows, and have been actively supported by clinical leaders via our senate:

- Renal services – looking to establish a north London provider-led collaborative to develop renal services, working closely with primary care e.g. to manage CKD pathways.
- Neuro-rehabilitation – linking into local development in WEL of level 2b neuro-rehabilitation beds currently provided out of the local area, making better use of specialist staff at Barts Health and Homerton Hospital for level 1 beds, improving access for the most seriously ill patients and improving earlier discharge where appropriate.
- Cardiac services – working with secondary and primary care to improve pathways and reduce demand on specialist services.
- HIV – integrating services commissioned by NHSE, CCGs and eventually local authorities to create 'one stop' access for people living with HIV.
- Sickle cell and Thalasemia – bringing together commissioning of inpatient and community services to promote out of hospital care and reduce unplanned admissions.
- Mental health – led by ELFT, create a provider-led collaborative across north east and north central London to improve access to urgent hospital care for CAMHS

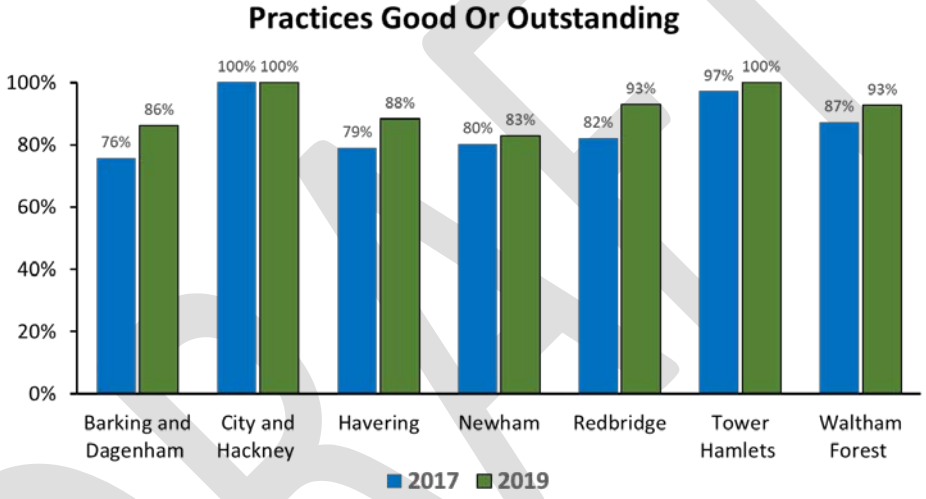
patients, reducing inappropriate out of are admissions and reducing length of stay by investing in local CAMHS services.

By March 2021 the intention is to have established new working arrangements in each of these areas, with a priority on renal network development and re-design of the neuro-rehabilitation services at Homerton and Barts Health.

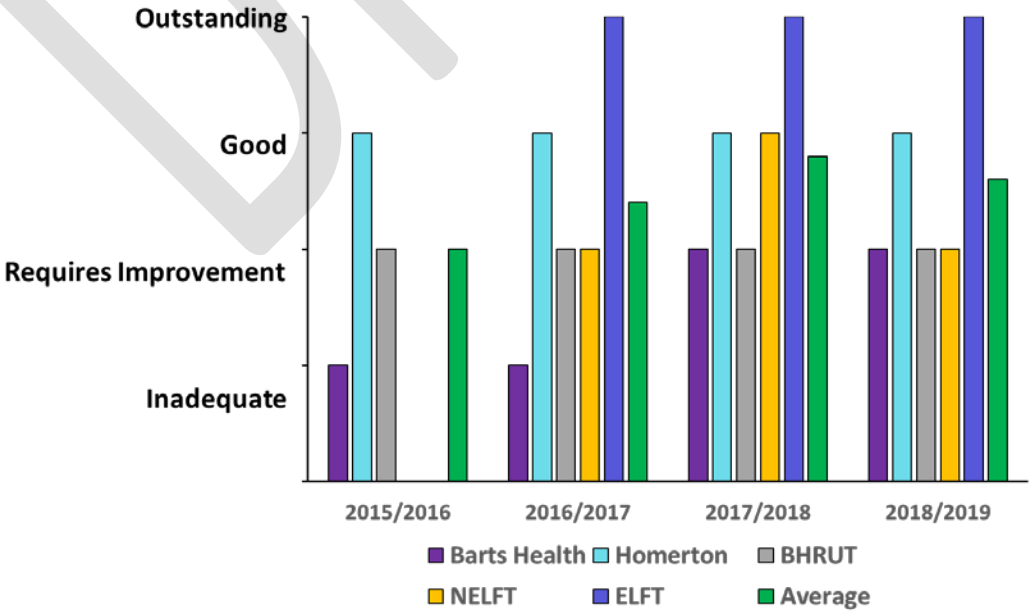
Improving quality

As highlighted in the figures below, there have been significant improvements in CQC ratings across our GP practices and main providers since our previous Plan was developed in 2016. There is now the opportunity to harness the opportunity offered via quality improvement methodology (see chapter 6) to embed cultural change across our systems, learning from organisations and areas which have well-developed programmes.

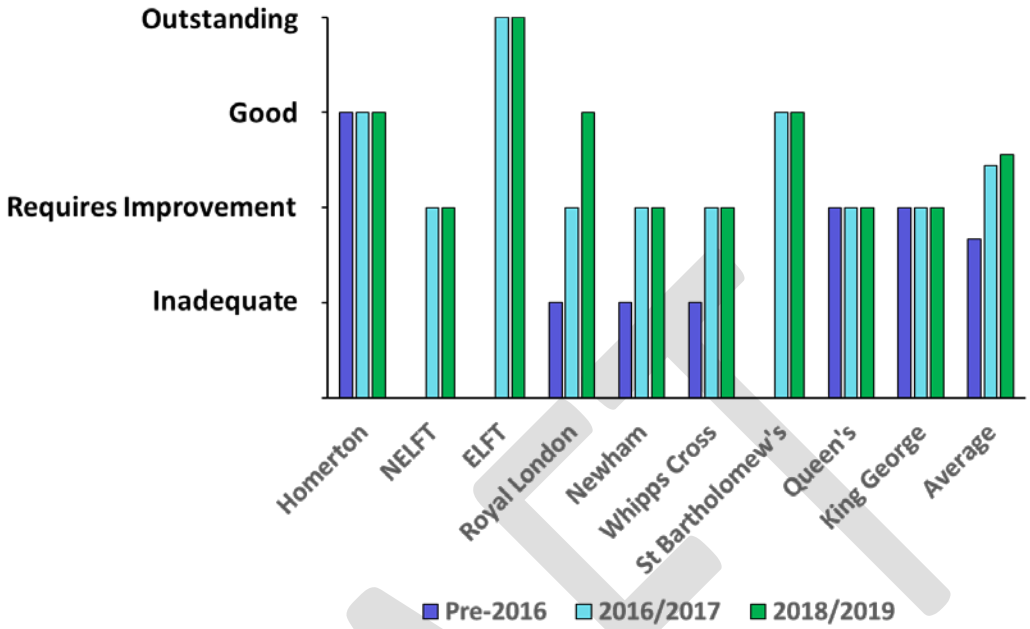
CQC ratings for north east London GP practices



CQC ratings by provider 2015/16 to 2018/19



CQC ratings by provider and site 2015/16 to 2018/19



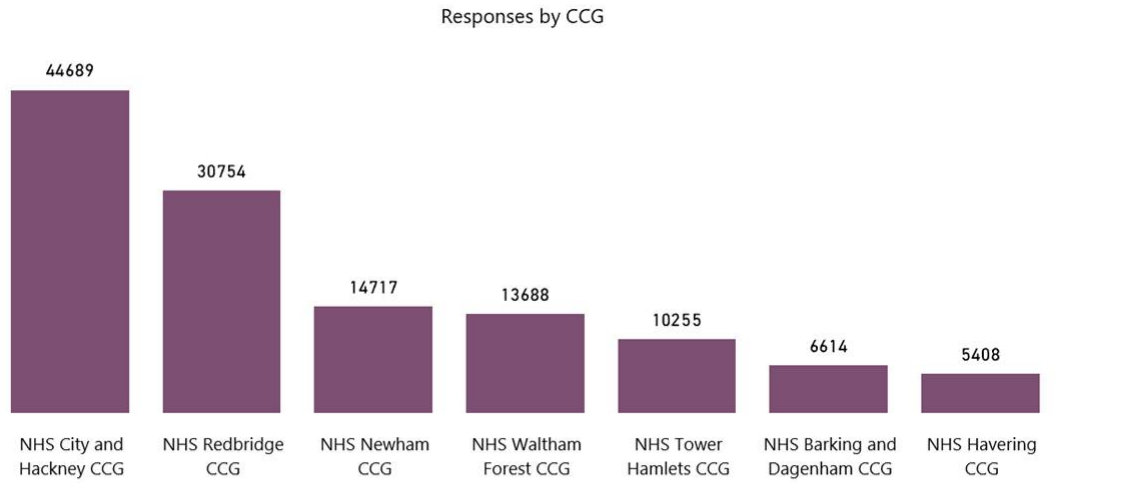
Patient experience

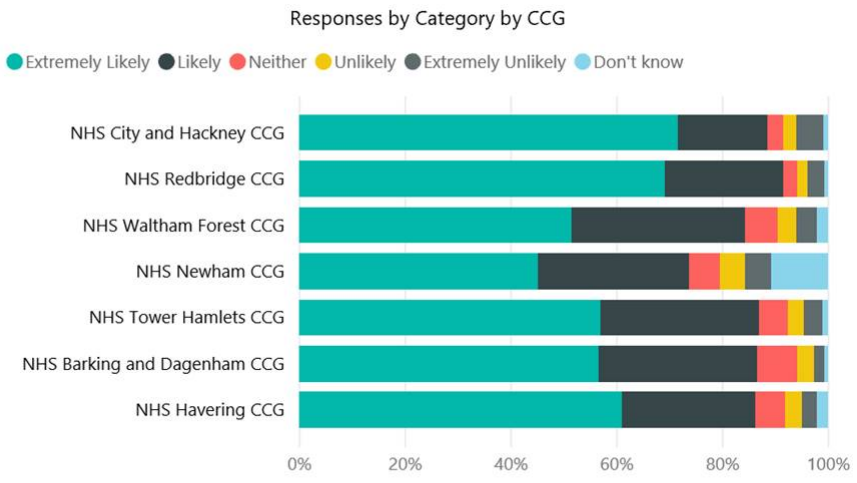
All NEL CCGs are part of the local NHSE/I led quality surveillance group (QSGs). This is made up of the 7 CCGs in north east and the 5 CCGs in north central London in line with recommendations made by the national Quality Board. Prior to each of our joint meetings a quality risk log is circulated about all providers (acute to care homes) and quality concerns are then discussed in detail. Key stakeholders attend including HEE, CQC and specialised commissioning.

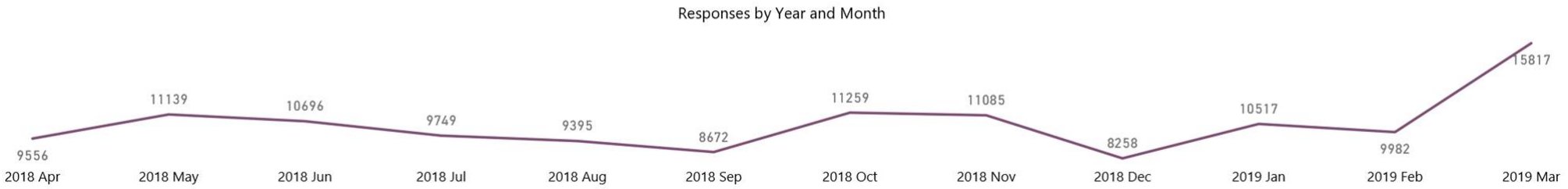
A core measure undertaken and monitored across NEL is that of the Friends and Family Tests (FFTs) which indicate the patient experience. The Homerton Hospital's recommended FFT rates are generally better or comparable to the London average. Barts Health rates are generally improving particularly for inpatients and maternity, whilst the BHRUT FFT performance for A&E showed steady improvement between Q1 and Q2 but declined in Q3 2018/19. ELFT Mental Health FFTs in 18/19 indicated that 90% of the patients surveyed recommended the service which was consistent with the results in 17/18. There was an improvement in the NELFT Community FFTs ending the year with 96% of people recommending the Community Health services.

The diagram below indicate the FFTs for NEL GPs. There are variable scores across NEL with Redbridge and C&H scoring in range of the London average.

Friends and Family Test: Results for NEL GP Practices







Primary and Community Care

Investing in primary care and community services

Primary care in north east London will benefit substantially from the investment commitment of £4.5bn in real terms between 2019/20 and 2023/24. Detailed financial plans will be developed at local system level and collated across north east London. This investment will contribute to both our strategic aspirations for primary care, as well as our wider out of hospital services. Further details is provided in the finance section of this plan and in the strategic planning tool submission.

Primary care networks across north east London

A principal objective of our NEL primary care strategy, supported by funded national and regional investment plans, is to develop PCNs in line with the London-wide larger scale general practice vision. These PCNs will act as key building blocks to strengthen primary care and support local service integration. They will enable multi-disciplinary working across all health, social care and the voluntary sector. We are also keen to maximise their potential to become a vehicle for local NHS investment, including improvements in premises. We anticipate benefits for patients in terms of access – we will end half-day closing and provide extended hours appointments.

Patients will also gain from a range of service developments in primary care via seven new services to be delivered through PCNs from April 2020 onwards. PCNs will be required to deliver a set of seven national service specifications. Five will start by April 2020:

- structured medication reviews
- enhanced health in care homes
- anticipatory care (with community services)
- personalised care
- supporting early cancer diagnosis

The remaining two will start by 2021:

- cardiovascular disease case-finding
- locally agreed action to tackle inequalities

Finally, there will be improvements for patients and staff through the introduction of new multi-disciplinary roles via Networks – these roles will help manage workload in primary care, improving access and the experience of patients.

Establishing the infrastructure for PCNs during 2019/20

From July 2019 all practices have been members of a PCN, covering areas of between 30-50,000 patients. Each PCN is a group of separate GP practices who have chosen to join forces with each other, which will help them address the increasing challenges faced by general practice. The PCN list size is the sum of its constituent practice members. There are 47 PCNs across NEL, as set out below.

PCNs across north east London

City And Hackney	8
Tower Hamlets	8
Newham	10
Waltham Forest	7
Redbridge	5
Barking and Dagenham	5
Havering	4

The focus of our work in 2019/20 is to build the infrastructure and foundations of PCNs consistently across NEL, so that they are ready to deliver a range of service specifications from April 2020 onwards, as well begin employing a range of multi-disciplinary staff. We have recently been supporting at-scale working in primary care through close collaboration with GP Federations over the last two years, in line with the London-wide larger scale provider strategy. We are now in a strong position to support the new PCNs through both national development support, as well as a system-wide programme based upon a self-assessment process. PCNs have already been strengthened by the appointment of clinical directors for each Network, who will be able to provide local leadership as well as provide a voice for primary care across the system. In addition, there will be an investment in organisational development for PCNs, which will help to introduce new ways of working across local systems.

Primary care and community services transformation

As outlined in chapter 2, local systems have been developing their integrated out of hospital community service models, reflecting the needs of their local populations and local collaborative arrangements across organisations. The development and strengthening of these integrated service models in systems is taking place concurrently with the establishment of PCNs. Several of the new PCN specifications for April 2020, specifically the specifications covering enhanced health in care homes and anticipatory care, will be developed by the national team to cover both primary care and community services. Once ready, these specifications will detail the expectations on commissioners and providers to create integrated care at a Network level and ensure primary and community services work in partnership to enable care delivery. Before the establishment of these arrangements via the national contracts, each local system has responsibility for aligning the commissioning and development of out of hospital services around PCN footprints, ensuring that health, social care and the voluntary sector are able to collaborate according to patient need. Local organisational development and change programmes will be supporting systems and teams to work in new ways and enable collaboration.

There will be specific preparatory work by local systems to support these developments before the release of the new specifications. Each local system will review their care homes offer against the vanguard model and develop a plan to address funding and workforce requirements by 2020/21. They will also work with primary and community services for anticipatory care delivery, ahead of the publication of the national service specification.

Plans are also being drawn up at a local system level to address community crisis and reablement response times of two hours. The NEL workforce programme will quantify the need and plan additional staff recruitment to deliver these targets by 2023/24, and outline the potential of maximising workforce efficiencies through provider collaboration on key aspects of the Carter Review.

In terms of the system impact of new integrated out of hospital models of care on downstream hospital NHS utilisation, we will review historical datasets of impact across our local systems. In particular, there have been trends in the City and Hackney system towards a lower growth in emergency hospital admissions and we will be discussing with this system about any learning that could be applied elsewhere, and in particular if there are any ways of showing quantified impacts via new integrated community-based services.

Primary care workforce development

We will invest an estimated £30m over the next five years in new roles to bolster the workforce in PCNs and ensure patients have access to a wide range of specialist care and professionals. The investment is equivalent to an additional workforce of 650 FTEs who will support the existing workforce in delivering new services working alongside colleagues from community and mental health services, social services and the voluntary sector. The investment will include at least:

- 120 social prescribers referring people to link workers from a wide range of local agencies
- 250 clinical pharmacists supporting GP practice colleagues by undertaking structured medication reviews to support patient centred care in managing long term conditions
- 90 physicians associates who can provide continuity of care for patients with LTC as part of multi-disciplinary team working under the supervision of the GPs
- 130 physiotherapists offering first contact services to patients, including advice and care, onward referral and self-management support
- 45 community paramedics offering home care support to the most vulnerable patients.

PCNs will recruit to these roles in line with patient need over the next five years whilst at the same time increasing the numbers of GPs, nurses and health care assistants working in practices. We will support PCNs and practices to identify their workforce pipeline requirements, working closely with Health Education England. In addition, we will be introducing local NEL primary care workforce training hubs, supported by HEE and local CEPNs, to provide at scale educational programmes for primary and community care staff. This will support us in our goal of offering continuous professional development opportunities for each primary care professional category across NEL. Other key aspects of our primary care workforce programme are:

- Continuing our focus on GP retention. From 2019/20 we will have implemented salaried portfolio schemes for all newly qualified GPs who have finished their training, and we will further develop these schemes with the goal of increasing the number of GP trainees remaining in north east London following completion of their training
- Building on the success of targeted careers fairs for GP trainees and physician associates held in 2018/19, we will develop an annual careers fair for all primary care staff groups over the course of the long term plan.
- Developing new innovative primary care employment models that offer more sustainable roles for primary and community care staff and address inequity of terms and conditions.
- Training and developing our current workforce to prepare them for a transformed system, as well as training staff for new roles such as physician associates and nursing associates
- Establishing professional leadership for nursing and other direct patient care groups
- Exploring ways to support admin and management staff groups

Developing primary care digital services

By April 2020 all patients will have online access to their full patient record and by April 2021 all patients will have the right to online and video consultations. A range of specific primary care digital activities will be undertaken. These will include:

- Devising a digital acceleration strategy for NEL primary care services to expedite uptake of new technologies in practices
- Using digital technology to manage demand and improve clinician access to information
- Offering online consultations to 75% of the population by March 2020; from April 2020 all practices will be contracted to offer access to online consultations for their patients
- From April 2021 all practices will be contracted to offer access to video consultations
- Digital Acceleration to Roll out the NHS APP
- Integrating digital pathways across GP network hubs and unscheduled care services.

Key primary care development areas linking to other programmes

Quality and efficiency in primary care practice
The north east London primary care quality improvement programme will continue, with the aspiration that that 95% of practices in each borough achieve a CQC rating of good or outstanding. We will continue with our forum for sharing best practice in QI across NEL, with key aspects of our programme to include:

- Recruiting or training a QI expert per network
- Developing and measuring workflow optimisation in each practice throughout NEL
- Developing a NEL wide QI methodology to ensure consistent quality
- Implement besting practice key principles for at least five care pathways across NEL.

Primary care estates
In line with our estates strategy, we will develop plans to support general practice to gradually transition out of the existing estate, much of which consists of converted residential buildings, as investment is made in more modern premises.

Pending the outcome of the LTP review of estates our goals are to ensure that:

- Services will be delivered from facilities where practices can work together with access to on-site diagnostics (e.g. blood testing, ultra-sound and echo-cardiograms).
- Back-office functions will be shared to support new models of care so that more funding can be available for clinical services.
- We have a system that incentivises efficient and effective use of capital assets
- Delivers general practice in modern purpose built/designed facilities
- Consolidates unused and underutilised estates and develops a planned programme of disposal/transfer of properties to build an investment fund for local priorities

We also aim to have a premises policy. This policy is under consideration as part of a national pilot in conjunction with NEL estates and will build on the investment in the GP Forward View.

Urgent and emergency care (UEC)
The primary care and UEC work streams will continue to collaborate closely to ensure an integrated urgent care pathway for patients across primary and urgent care services. This will involve the alignment of extended hours service provision with the development of PCN delivery via the new Primary care contract direct enhanced services. There will also be development of a new digital first access to primary care, as well as the implementation of physio first.

Outline implementation plan for primary care

By the end of 2019/2020	By the end of 2020/2021	By the end of 2021/2022
Focus on PCNs' formation, support for sustainability and building relationships with providers • NEL primary care network development framework has been jointly developed and agreed for consistent system support for PCNs • GP Federations across NEL are at least on medium (step 2) maturity level • PCN profiles have been developed incorporating health, social and public health data for comprehensive population health management • Each PCN has agreed its immediate priorities • PCNs maturity and needs assessment is completed and an NEL-wide development support plan is agreed and implemented • Leadership courses have been offered and attended by all PCN clinical directors • NEL primary care workforce plan is developed and agreed • 90% PCNs have recruited to the network additional roles • Community services and PCNs have made proposals to align services to support delivery of five nationally mandated services • Various new models of care have been explored through NEL new models group	**Focus on the delivery of NEL Primary Care Strategy aspirations and rolling programme of primary and community services alignment** **GP federations** • Mature federations in each borough delivering population-based outcomes via networks who are working in collaboration with partners to deliver MDT • PCN clinical directors are represented at appropriate levels of the system to strengthen the voice of primary care • All GP federations have standardised processes, policies and procedures, so that all staff are treated and supported equally across NEL • Each practice has online consultations available to its patients **Workforce** • A local salaried portfolio scheme for new and existing GPs is implemented across all boroughs • Each additional professional category in PCNs has continuous professional development opportunities across NEL • Primary care workforce training hubs are developed at local level • Future primary care workforce requirements and relative pipelines have been identified • New employment models have been explored and developed for primary and	**Focus on progress evaluation and re-setting of trajectories** • NEL primary care strategy is refreshed • Rolling programme of community services' alignment with PCNs in each borough • Comprehensive assessment and evaluation of progress to date and refresh trajectories accordingly • PCNs shared savings scheme for reduction is A&E attendances and admissions in place • All locally enhanced services contracts added to network contracts • 50% of NEL population have access to digital first primary care offer **National requirements of PCNs:** • CVD case finding requirements start • Prevention and inequalities requirements start

	community staff to offer more sustainable roles **Quality improvement** • All practices have achieved a minimum 95% CQC rating • NEL wide QI methodology has been developed and implemented • Each network has a minimum of one QI expert • Each practice has undertaken workflow optimisation techniques • Best practice key principles are implemented for at least five care pathways across NEL **Estates** • Proposals have been made for Primary Care Estates development in line with the NEL estates strategy **Digital First** • NEL Digital First programme starts **National requirements of PCNs:** • National structured medication review requirements start for priority groups • Care homes requirements apply • Personalised care requirements start ▪ Gradual increase in expected activity levels over several years • Anticipatory care requirements start • Early cancer diagnosis support requirements start	

Social care

Social care services, for both adults and children, are key to delivery of the ambitions for integrated care outlined in this document. We are undertaking further work during October,

including an event on 16 October, where we will be working to detail our plans across the patch. We will therefore be including much more on this in our final draft Plan submission.

Planned care and outpatients

Our growing population means increased demand for elective care services. Between 20/21 – 23/24 we anticipate growth of between 1-2.5% across NEL for elective care services. In line with this, elective care capacity has been consistently constrained, leading to increased waiting times for our patients. In addition we expect the number of patients with LTCs, or an ongoing need for treatment, to account for a growing proportion of elective care activity, increasing the complexity of providing care. This means that we have to provide elective care services in a more efficient and effective way, to manage this demand and deliver the high standard of care our patients expect.

The elective care programme will prioritise on delivering:

1) Reducing waiting times for our patients, and eliminating waits over 52 weeks
2) Ensuring we use our resources and capacity effectively
3) Reducing unnecessary demand, to ensure capacity is available
4) Increasing the use of digital and non-face to face solutions for the provision of services.

Current position and trajectories of programme

Our elective care programme is coordinated through the demand and capacity group, which links into London region elective care steering group. The group is well established and its memberships includes senior provider and commissioner representatives.

Over the past year, the elective care programme has focused on sustainably reducing patient waiting times, by ensuring we have the right process in place to manage lists effectively. The elective care programme has coordinated the roll out of E-RS capacity alerts and has been supporting the review of advice and guidance services to more effectively manage demand across the system.

NEL ended 2018/19 broadly achieving constitutional standards linked to elective care (RTT, Diagnostics waits and Cancer), however this was not universal with performance issues at BHRUT in particular. Overall waiting lists grew over 2018/19 despite referral levels declining.

Entering 2019/20, our providers have faced a challenge in consistently delivering diagnostic waiting time standards, with both BHRUT and Barts Health not achieving the standard. This has meant that patients have waited too long to receive tests. We still have patients waiting over 52 weeks to receive their treatment, increasing clinical risk and making for poorer patient experience. All organisations submitted compliant trajectories to achieve the end of year performance positions. We have agreed ambitious but realistic trajectories for 2019/20 and beyond, as part of our strategic planning tool submission.

The elective care programme has the following key challenges:

1) Our providers are facing capacity constraints across specialities with high patient demand
2) Our elective care pathways vary across NEL and when compared to best practice pathways
3) Delivery of constitutional standards continues to be a challenge, particularly in terms of Diagnostic waits and RTT
4) Delivery of QIPP programmes has yet to have the expected impact on outpatient activity

5) Current constraints on diagnostics capacity (particularly in endoscopy and related procedures).

The elective care plan
The overarching aim is to radically improve the delivery of elective care services, enabling patients to have access to the right advice, care and treatment in the most flexible, timely and effective way possible. This programme will address the challenges in delivering the RTT (18 weeks), diagnostics and cancers national standards, including acute operational delivery, primary care demand management and implementing a strategic approach towards capacity management across NEL.

We will focus on:

- Ensuing sustainable delivery of the constitutional standards related to waiting times, and reducing the time patients wait for care
- Developing and embedding a NEL approach towards mutual aid, enabling patients to access available capacity across NEL in a timely fashion
- Including a NEL approach towards 26ww plus increasing usage of technology to mitigate demand
- Supporting the delivery of transformation plans within local systems, including the usage of best practice (such as FCP models of MSK care)
- developing a strategic approach towards the future management of demand and capacity across NEL over the course of the LTP
- reviewing existing diagnostics capacity across NEL and developed a revised Demand and Capacity model to support early diagnosis.

Plan to deliver the programme

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Implement the 52 week wait penalties process to support demand and capacity programme Review the impact of capacity alerts Scope the demand and capacity review (includes diagnostic capacity) Eliminate waits of over 52 week for patients	Implement the 26week wait policy Deliver first phase of the demand and capacity review Implement mutual aid programme between providers	Deliver second phase of demand and capacity review

Transforming how we deliver urgent and emergency care

There is increasing demand for health services and we are keen to support a move away from relying on urgent and emergency care services, freeing them up to concentrate on the most serious and urgent cases and understand at how primary and secondary care services can support urgent and emergency care (UEC).

Rising numbers of people are obtaining the health care help they need either by phone or online and spending less time in A&E or calling for an ambulance. Therefore the aspiration is to continue with developing the NHS111 Clinical Advice Service (CAS) as part an integrated network of community and hospital-based care joined through governance and digital interoperability. Patient education and behaviour is a key area of work – we need to make

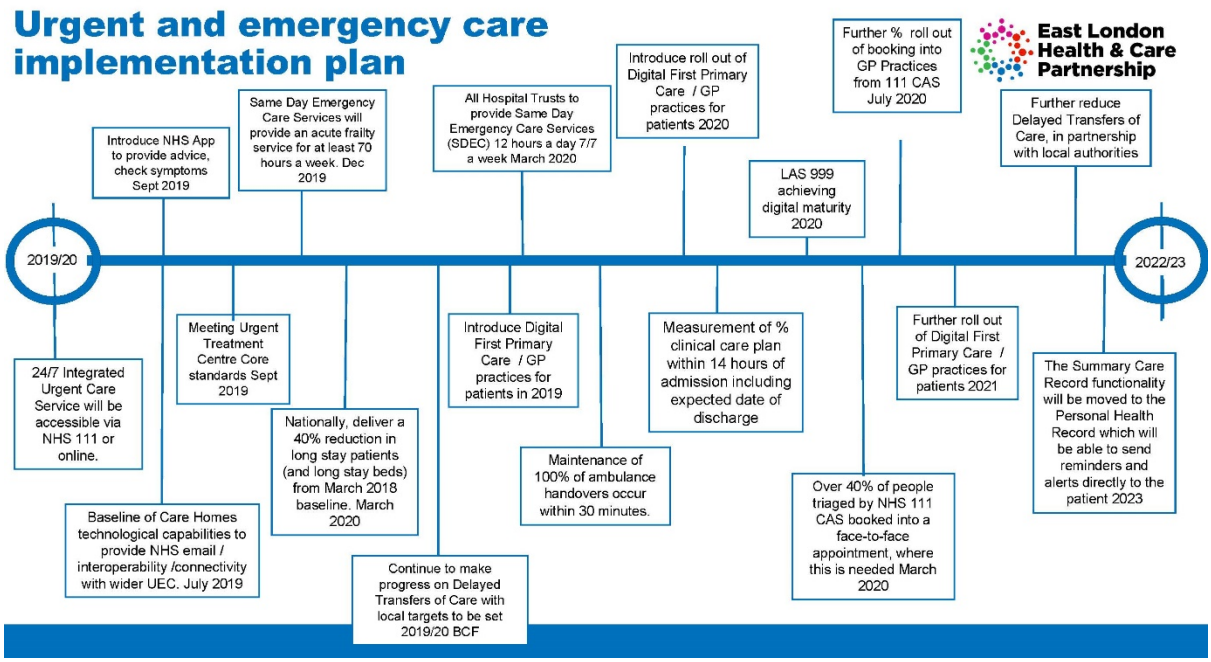
sure patients have the resources they need to make the right decisions about the sort of care they need.

The overall objective of the UEC programme is: 'To create a simplified, streamlined urgent care system, which will ensure right care, right place, first time access principles for patients in north east London. The NEL urgent and emergency care system will be able to respond to current and future demand, whilst meeting quality standards, within a financially stable framework and while meeting the requirements of the Five Year Forward View and the NHS Long Term Plan'.

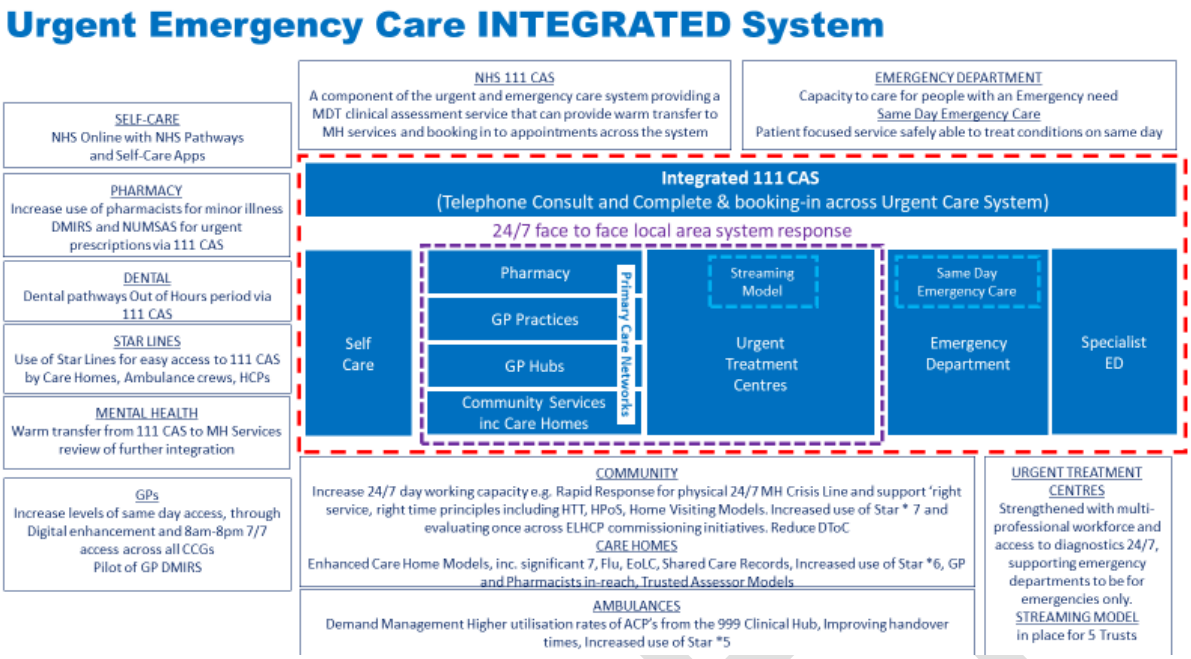
Achievements so far:

- the development and implementation of an enhanced NHS 111 CAS in 2018. Over 50% of callers now receive a clinical assessment where they are offered immediate advice or referred for a face-to-face consultation; these consultations can also be booked out of hours where clinically necessary. People also have access to the NHS 111 online service. The CAS is also able to transfer to mental health crisis services within NEL where clinically necessary.
- Met target to reduce 'A&E by default' selections on the Directory of Services (DoS) to less than 1% by the commissioning of appropriate services that are accurately recorded on DoS.
- Urgent treatment centres (UTCs) are being rolled out and appointments will also be bookable via NHS 111 CAS. Same day emergency care (SDEC) services are also being introduced as an alternative to those not admitted overnight.
- The 'Fit to Sit' initiative has been introduced to A&E allowing faster turnaround of ambulances. Emergency care data set (ECDS) are being rolled out to the major A&E departments to better understand why the local population attend A&E.
- 203 out of 379 NEL pharmacies are now providing the urgent repeat medication service, and care homes are able to access further end of life care training to support residents nearing end of life
- Maternity pathways have been developed which allows 999 to book directly to labour wards without the need to attend A&E.

UEC implementation plan



The delivery of the UEC programme will work in an integrated way with our partners across health and social care:



Current challenges include the effective collaboration between multiple organisations linked to establishing a consistent approach across the footprint and maintaining performance while making changes to meet growing demand. This relates to managing patient and workforce expectations alongside required adaptations to their behaviour toward services. Digital challenges surround data sourcing and linkage across complex integrated urgent care providers which would help better understand the impact of factors driving demand.

The UEC programme implementation plan aims to deliver:

- Designated urgent treatment centres (UTCs) across several sites within NEL which will meet the national core standards. All hospital trusts to provide same day emergency care (SDEC) by March 2020, through working with acute trusts to transform ambulatory care units. A reduction in length of stay of care home patients in hospital via enhanced health in care homes e.g. supporting PCNs to implement medication reviews within care homes. This is linked to establishing better relationships between health and social care which includes providing wider access to the health system, such as via supporting care homes to attain data and security protection leading to NHS mail access.
- Integrated urgent care services through our 24/7 NHS 111 Clinical Assessment Service (CAS). The service is accessible through NHS 111 telephone and NHS 111 online services and provides improved access to urgent health care based on patient need. Concurrently the ability to directly book face-to-face GP appointments via the CAS where deemed necessary is being developed. Jointly the CAS will be utilised to deliver the national priority of a single urgent community response; leading to its development toward a simplified service allowing access to GPs, ambulance services and community teams.
- The 40% reduction target in long length of stay patients from our March 2018 baseline to meet local delayed transfers of care ambitions. To enable these objectives to be met we will implement the Better Care Fund's discharge patient tracking list (DPTL) within each acute provider. Correlated to this will be monitoring the percentage of patients provided with a clinical care plan (including expected

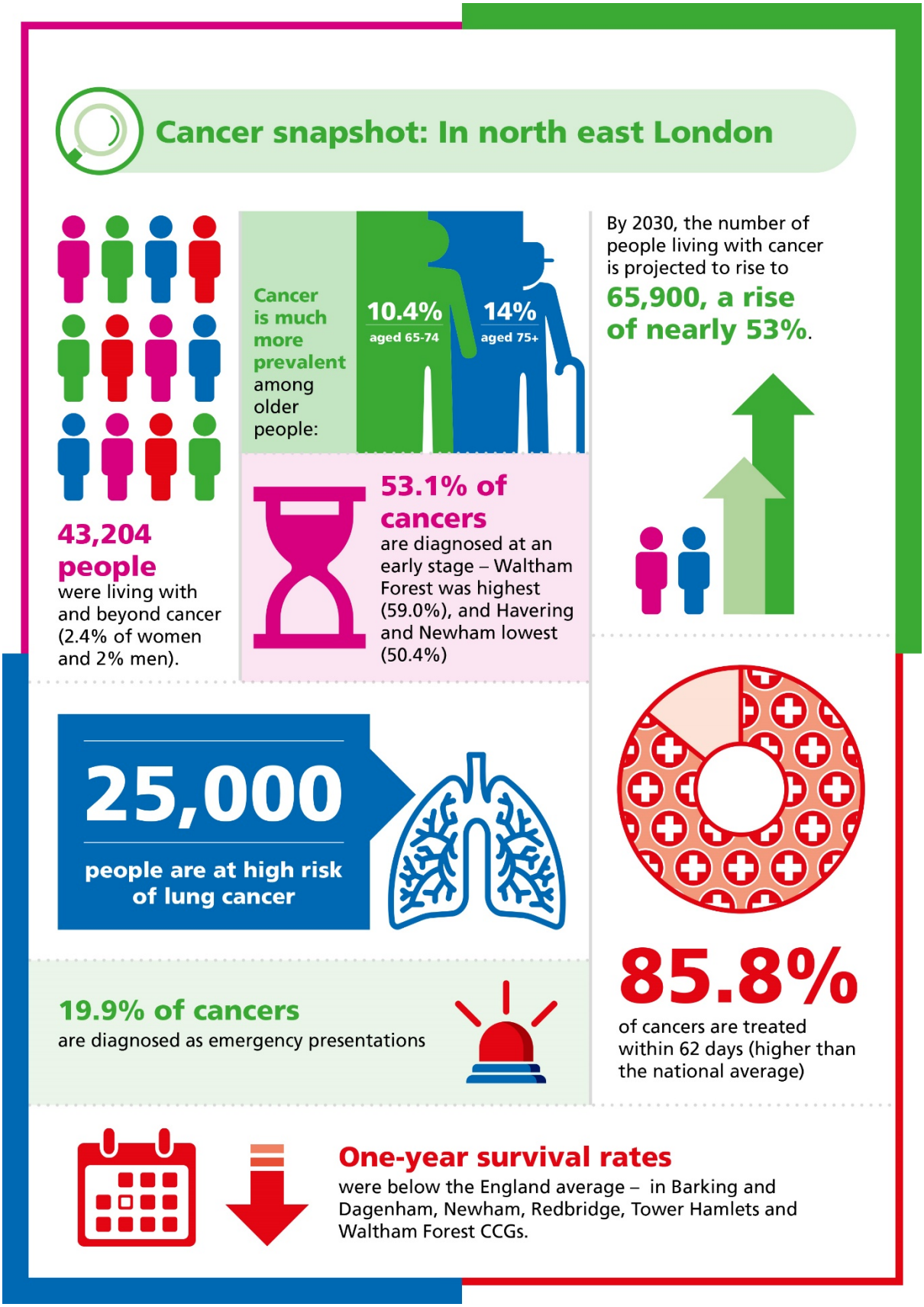
discharge) within 14 hours of admission. Further partnership collaboration with local authorities will also further aid reduction in DTOCs.

- A reduction in avoidable conveyances by ambulances to A&E while ensuring 100% of handovers occur within 30 minutes by Q4. This will be achieved by implementing the published guidance (summer 2019). Ensuring that London Ambulance Service paramedics have access to patient records and pathways, and that access to clinical support and relevant training. Thus allowing for hospital avoidance via utilisation of pathways for falls, rapid response, catheter management and mental health. Developing and establishing an ambulance dataset bringing national ambulance data together this will allow for benchmarking and baselining for potential call volumes e.g. for community response and mental health.
- The summary care record functionality will be moved to the personal health record which will be able to send reminders and alerts to patients directly by 2023. We will support the roll out of the Personal Health Record to UEC providers as well as increased access to Coordinate My Care across all UEC providers.

A&E at King George Hospital

The Accident and Emergency unit at King George Hospital will remain in place. The local population has changed significantly and is forecast to change further and there is a clear need for this provision at both now and into the future. The A&E will continue to be a consultant-led service, open 24 hours a day, with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients (known as a Type 1 emergency department).

Cancer


Cancer snapshot: In north east London
43,204 people
were living with and beyond cancer (2.4% of women and 2% men).
Cancer is much more prevalent among older people:
10.4%
aged 65-74
14%
aged 75+
53.1% of cancers
are diagnosed at an early stage – Waltham Forest was highest (59.0%), and Havering and Newham lowest (50.4%)
By 2030, the number of people living with cancer is projected to rise to
65,900, a rise of nearly 53%.
25,000
people are at high risk of lung cancer
19.9% of cancers
are diagnosed as emergency presentations
85.8%
of cancers are treated within 62 days (higher than the national average)
One-year survival rates
were below the England average – in Barking and Dagenham, Newham, Redbridge, Tower Hamlets and Waltham Forest CCGs.

Cancer is a key national and local strategic priority. Our aim over the course of the next five years is to improve survival rates and the support in place for people living with and beyond cancer, as well as to develop more personalised care. This is an important priority for us, as we are expecting a significant increase of up to 53% of people living with cancer by 2030. There have been improvements in the early diagnosis of cancer both nationally and locally. However, some of our areas continue to have a disproportionately high level of late diagnosis, particularly Tower Hamlets and Barking and Dagenham, which we need to address in the next phase of our work programme. As well as reducing the variation in diagnosis and treatment of cancer, we will be ensuring faster translation of innovation and research into practice for the benefit of local people.

We will build on our successful National Cancer Vanguard programme, which has been led through the UCLH Cancer Collaborative/North Central and East London Cancer Alliance. From April 2020 NEL will have its own cancer alliance enabling us to develop a more focussed approach to our main challenges: major capacity constraints across our hospitals, particularly in workforce, poor cancer screening uptake and unwarranted variation in referral rates from general practice. The alliance will include all key health and care stakeholders, including third sector partners such as Cancer Research UK and Macmillan Cancer Support. The programme of work over the course of the next five years will cover three main areas: improving survival rates, addressing capacity challenges, and improving services for cancer survivors.

Improving survival rates

Improving survival rates will depend upon improvements in three areas:

1. **Early diagnosis** - we will undertake engagement with our populations on the importance of screening programmes and symptom awareness, supported by our GPs and public health colleagues. North east London benefits from three of the largest studies to improve cancer diagnosis: FIT (for patients at high risk of colorectal cancer), SUMMIT (for lung cancer) and HPV self sampling (for cervical cancer). We will roll out new forms of testing based on these programmes. In addition, we will continue working with our GPs to help improve referral rates for suspected cancer, implementing cancer specific education sessions in primary care and engaging with the newly formed PCNs.

2. **Ensuring faster translation of innovation and research into practice** In addition to the studies outlined above, NEL will continue to benefit from a close relationship with QMUL and the running of a large number of clinical trials across our main cancer hospitals. We will also ensure collaboration with cancer clinical trials programmes across the UCL Partners footprint, with close links to the NHS genomics programme.

3. **Reducing variation in diagnosis and treatment** The NCEL Cancer Alliance supports 20 tumour pathway boards and expert reference groups made up of clinicians and patients whose central role is to reduce unwarranted variation. We will continue with this approach over the course of the long term plan, ensuring latest guidance and treatments are being implemented and surgical expertise utilised to achieve the best outcomes.

Addressing our capacity challenges to meet rising demand

The biggest challenge for cancer services is increasing capacity to meet rising demand. We are forecasting shortfalls in specific professions who are essential for diagnosing and treating cancer (e.g. radiology, pathology, gastroenterology, oncology, specialist nursing). We will address this through increasing training, as well as upskilling a wider group of clinicians in key clinical tasks. We will also increase the implementation of evidence-based protocols via multi-disciplinary team meetings, speeding up the decision making process for patients. We will increase our screening capacity, partly through our continuing support for large-scale lung screening, as well as increase our diagnostic testing capacity through the introduction of new types of tests. A key outcome from these interventions will be an

increase in the number of cancers diagnosed at stage 1 and 2 – moving up from our current position of 52% towards our strategic 10-year aim of 75%.

Improving services for cancer survivors

Due to the success of treatment, more people are surviving cancer than ever. In collaboration with organisations such as Macmillan Cancer Support, we are working with providers to ensure that everyone diagnosed with cancer receives a holistic needs assessment and that their care is transferred to a GP with clear communication enabling appropriate support. People living with and beyond cancer often have financial difficulties, and professionals can refer for specific financial advice and support. We are developing innovative ways of working between cancer specialists and primary and community care to ensure that people receive ongoing support closer to home, including personal health budgets and social prescribing.

By the end of 2019/20	By the end of 2020/21	By the end of 2022/23
Improved screening plans implemented • HPV vaccination for all boys aged 12 and 13 • The Faecal Immunochemical Test as part of the bowel screening programme. • The HPV primary screening for cervical cancer Establishment of a Rapid Access Diagnostic Centre - two vague symptom pathways in operation across NEL All Trusts to be collecting FDS mandatory data items We will deliver demonstrable improvement in numbers of lung, prostate and colorectal cancer patients diagnosed in 28 days We will implement the timed pathway for oesophago-gastric cancer across all Trusts	All local systems should be recording their Faster Diagnosis Standard data (From April 2020) All providers to be meeting the Faster Diagnosis Standard Implementation of tool - 'C the signs' - to streamline referral process Implementation of 'e-safety netting' module, integrated with GP IT systems, across NEL PCNs Improvements in children and young people's cancer services through implementation of new service specifications Increased access to appropriate genomic testing for NEL patients through the Genomic Laboratory Hub and NHS Genomic Medicine Centre. Implementation of key aspects of personalised care: needs assessment, a care plan and health and wellbeing information and support.	Significant improvements will be made on uptake of the screening programmes. By 2023 the first phase of the Targeted Lung Health Checks Programme will be complete, with a plan for wider roll out (depending on evaluation). Systematic approach adopted a PCN level for improvements in early diagnosis for cancer patients Increased uptake in clinical trials for cancer patients, particularly for children and young people Plans for personalised follow up for all cancer pathways to be implemented

north and east London Radiotherapy Network established, hosted by UCLH All breast cancer patients to receive a personalised follow up post treatment. Two-thirds of patients who finish treatment for breast cancer to be on a supported self-management follow-up pathway All Trusts to have in place protocols for personalising/stratifying the follow up of prostate and colorectal patients and systems for remote monitoring for patients on supported self-management.	All prostate and colorectal cancer patients to receive a personalised follow up post treatment. All Trusts to have personalised (stratified) follow-up pathways in place for colorectal and prostate cancer by April 2021 Analysis of NEL data from the new Quality of Life (QoL) Metric to be used to drive improvement planning Recruitment of an additional 1,500 new clinical and diagnostic staff across seven priority specialisms to be complete	

Spotlight on: Rapid Access Diagnostic Centre

Late diagnosis of cancer is a particular problem for our local population, and we have some of the highest rates of late diagnosis in England. The RADC is a collaboration between the three main acute providers - Barts Health NHS Trust, Barking, Havering and Redbridge University Hospitals NHS Trust and Homerton University Hospital NHS Foundation Trust. It will improve access to earlier diagnosis and treatment for cancer, in particular, which will improve life expectancy and begin to address health inequalities.

The RADC will be person centred, with patient choice, attendance and patient experience supported by new clinical nurse specialist roles, which Macmillan has already indicated an interest in funding. The first phase for the centre will consist of two endoscopy suites and two ultrasound rooms, co-located with an existing CT scanner for low dose CT lung cancer screening. The second phase is to add an MRI machine.

A co-located education centre will be used to host a range of health and wellbeing events to educate on the rationale for screening and surveillance. It will also host events, building on the piloted health and wellbeing school developed to safety net pathways, educate on cancer prevention, provide health promotion, screening services and the small “c” symptoms to inform of the symptoms and signs of cancer with the intention of promoting a clinical review.

The RADC will be the first of its kind. The facility will be staffed with a mixture of existing members of provider staff and new staff, and as such will be a new model for service delivery at a system level. It will be a centre of excellence ensuring best practice surveillance and screening services whilst removing variation in delivery across providers.

This means all patients across north east London, whether receiving their diagnostics at a provider hospital or the RADC, will receive the same high quality care and standardised procedure. The RADC will act as a lasting platform for improvement by providing a centre for training, where new skills and techniques can be used and then disseminated across NEL.

Patients who have the opportunity to benefit from the RADC in phase one include those with gastrointestinal conditions such as polyps, Barrett's Oesophagus and inflammatory bowel disease, as well as those with liver cirrhosis and Hepatitis B and C. Phase two will extend to patients with early stage prostate cancer who are on active surveillance. The patient cohorts will be reviewed as the service becomes more established.

Patient outcomes and experience will improve by offering this new service. Patients will have greater choice over appointments, services will be co-designed to meet their needs and staff will be trained and skilled at managing their care and be able to refer onward if necessary. This new centre will provide much needed additional diagnostic capacity in our local health system.

The additional capacity will mean that more people in north east London are diagnosed with cancer sooner leading to improved life expectancy for these individuals and – in the longer term – lower cancer treatment costs. There will also remain an element of choice for local people in where they have their procedure as this is new, supplementary capacity.

Local people should also see an improvement in quality of diagnostics, as all three local providers are now working closely together to provide services to a common specification and will ultimately use a joined up IT platform to book appointments and for results to be viewed using the East London Patient Record.

The RADC will be a centre for best practice and training in surveillance and will spread specialist knowledge across the region.

The RADC has ambitious aims to provide additional cancer diagnostic capacity at a system level, removing unwarranted pathway variation and providing the ability for one stop diagnostics. This additional capacity in turn supports the 62 day standard and enables shortening timelines towards the 2020 Faster Diagnosis Standard reiterated in the Long Term Plan (informing of diagnosis by day 28).

The RADC will host a training centre for the key workforce areas of need (endoscopy and ultrasonography), expanding on the new clinical roles already trained within the system. There is also the opportunity to create shared posts, adding to the system workforce resilience in hard to recruit to areas. Furthermore, the quality improvement and person-centred holistic approach aims to improve flow and reduce system waste.

It is our intention to use the development of the St George's Health and Wellbeing Centre in Hornchurch to establish a second RADC.

Personalisation

Developing personalised care means ensuring people have choice and control over the way their care is planned and delivered, acknowledging individual preferences, strengths and needs. Our personalisation programme will be a cross-cutting programme of cultural change, implemented across our work streams and care sectors. We will build upon our strong legacy of leadership in social prescribing to co-create a personalisation programme with frontline staff, voluntary sector partners and patients. We will also use our contracting and commissioning experience to pioneer changes to provider budgets for mental health recovery and learning disability patients, which will give them both more control and choice.

Our personalisation plans, in line with the NHS comprehensive model for personalised care, will cover:

1. Social prescribing
2. Supporting self-management and enabling choice
3. Development of skills and behaviours
4. Personalised care planning and support
5. Shared decision making
6. Personal health budgets

Spotlight on: Social prescribing in Redbridge

Tackling isolation
A 56-year-old woman was referred to the social prescribing service run by Redbridge Council for Voluntary Services after experiencing social isolation and low-level mental health problems – and their visit was the first face-to-face contact she'd had in three weeks.

The woman's main concerns were loneliness, reduced mobility and housing issues. An hour-long detailed assessment by the social prescribing team highlighted the fact that numerous services had been in contact, though this had added to her confusion and feelings of being overwhelmed.

The social prescribing coordinator contacted the council's adult social care team and arranged for a volunteer to spend some time with her during the Christmas period, a time of year which had been particularly difficult in previous years. The volunteer also brought her a 'Christmas hamper'. "*You will never understand how grateful I am for the lovely lady coming to me. Sometimes, all you need is to know that someone is thinking of you at Christmas. I was feeling very lost with everything, but you helped me find the right people who are helping me".*

A place at her local day centre has been arranged, including exercise sessions and social events, while Redbridge Single Homeless Service is helping with her finance, transport and housing issues.

The introduction of interventions via social prescribing in this instance not only provided important support for this individual in the community, including over the Christmas period, but also proactively ensured that out of hospital services were maximised rather than relying on NHS and acute care at a time of crisis.

Advice and support
The social prescribing team were on hand to support a 27-year-old man with advice and support including counselling, English language conversation classes, a confidence-building course, training in trades and construction as well as immigration advice.

The team's health and wellbeing buddy felt that he needed immediate psychological support and looked into a specialist service for male survivors of domestic abuse, after hearing how his marriage had ended and he had experienced violence from his ex-wife and her family.

A range of social prescribing services were then provided, addressing his needs including education, training and employment advice.

Social prescribing

Our vision over the next five years is for social prescribers to have constructive input into all care and support plans, whether formulated in primary or community care, or at acute discharge. We will incorporate social prescribing across all of our work streams. We have conducted a stocktake both of the current level of social prescribing and voluntary sector capacity for referrals across NEL. Five boroughs currently have full coverage of social prescribing: Tower Hamlets, Hackney, Barking and Dagenham, Redbridge and Waltham Forest, with a variety of models in place. There is partial coverage in Newham and Havering, however there is a receptive local clinical community to the development of this service. Our first priority will be to ensure roll-out across these areas, so that there is a core social prescribing offer across all of NEL. We will work with the London social prescribing team to organise a clinical stakeholder event in the autumn at which we will look at ways to embed the concept of social prescribing. Key aspects of service developments across our social prescribing programme during 19/20 and 20/21 are then as follows:

- Ensuring that the voice of the service user is at the heart of shaping our social prescribing priorities.
- Supporting our systems to develop the link worker role. We will be running a specific workshop for link workers and current social prescribing providers: voluntary sector, primary care networks and local authorities.
- Creating a social prescribing network of professionals for NE London
- Developing a common outcome framework for social prescribing across NE London to effectively benchmark services.
- Exploring the opportunities for establishing common information systems and maximising the opportunities of digital technologies.
- Supporting primary care networks to develop their role in the social prescribing agenda
- Working across commissioners and providers to increase service uptake and maximize capacity.
- Our programme will be enacted in collaboration with the NHS regional team, particularly using central support for link worker training and overall programme support.

Spotlight on: 'I' statements in Tower Hamlets

People living in Tower Hamlets have produced a series of 'I' statements to underpin their expectations from local services.

The statements were developed by *Tower Hamlets Together* and indicate what matters most to local people under the headings 'around me', 'my doctors, nurses, social workers and other staff', 'me' and 'Tower Hamlets Together'.

They include statements such as 'I play an active part in my community', 'I feel like services work together to provide me with good care' and 'I have a good level of happiness and wellbeing'.

The statements aim to build trust and confidence in local services, highlighting the benefits of integrated care, partnership and collaboration among staff, patients and carers, the wider community and a range of other stakeholders.

These 'I' statements are increasingly being used by commissioners and providers to develop and plan services. They are also the basis for an Outcomes Framework, which is used to make the statements a reality for people in the borough in the next five years.

Enabling key aspects of personalisation: Personalised care planning and support , Shared decision making, Supporting self-management and enabling choice, Development of skills and behaviours

Care planning happens across all our care sectors, with a particular current focus on developing proactive care plans via local integrated care teams. We will seek to collaboratively create some common core principles for care planning, developed through consultation with patients and clinicians and endorsed via our clinical senate, which can be used across all our providers and systems. In addition, we will develop and implement a personalised care and support planning training programme for staff, which will incorporate both techniques to support self-management and promote independence. We will also establish an expert patient network to assist patients and clients with the care planning process, as well as establishing patient advocacy services as part of our overall approach. A key aspect across this work will also be to enable shared decision making as part of the care planning process.

We will work closely with our UEC work stream to embed the co-ordinate my Care (CMC) platform as the system through which care plans can be shared across organisations, ensuring that personal preferences for care can be understood and enacted at all times. We will also ensure the NEL-wide directory of services (DoS), encompassing health, social care and voluntary sector services, is available across all care settings. We will align the development of the DoS to our out of hospital digital plans, maximising the interface with the NHS App.

Finally, we will expand our Individual Placement Support (IPS) pilot across NEL, which will be integral to developing personalised care plans for many patients and clients with learning disabilities, mental health needs, and long term conditions. We will also work with local authorities and clients in the spirit of co-production to develop the local domiciliary care market through delivering revised market position statements, and supporting clients to come together and to work with the voluntary sector and social enterprise to co-produce new service offers and opportunities.

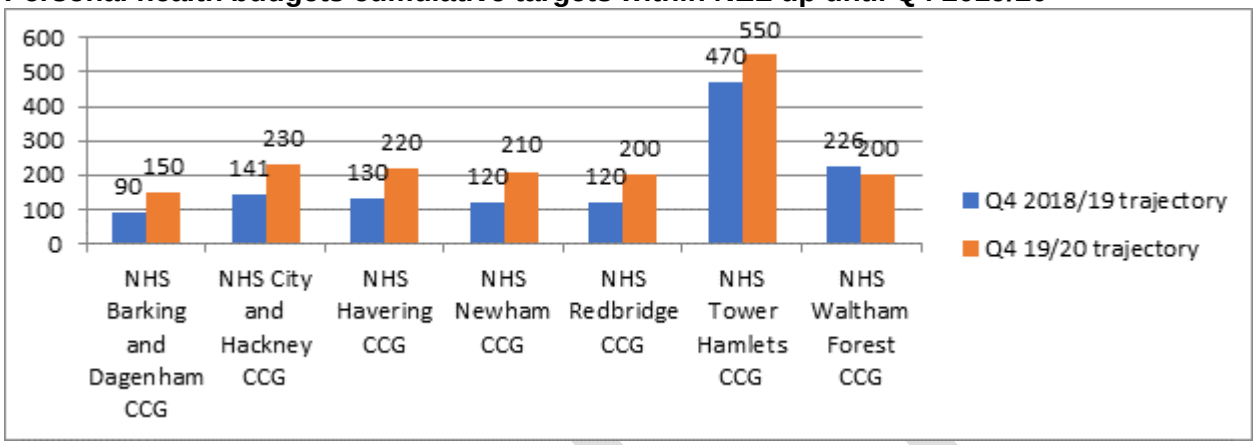
Personal health budgets

As part of our personalisation programme we will become the first area in England to disaggregate provider budgets within mental health recovery and learning disabilities. We will create a provider-led workstream to oversee the process, which will be supported by programme management arrangements. We will then establish a memorandum of understanding and gain-share and risk-share agreement between CCGs and providers to mitigate potential service destabilisation and to facilitate proper funding for training and the necessary extra posts. We will complete a local assessment on our ability to provide personal health budgets within all applicable clinical areas, including s117 packages of care; this will include producing authored local guidance to be implemented by CCGs. Our work with providers will ensure that they have the capability to provide personal health budgets to mental health recovery and learning disability clients and we will establish the financial mechanism to facilitate the administration of these budgets.

As part of this work, we will agree local trajectories for increasing personal health budgets over the course of 2019/20 and 2020/21.

We are currently working towards the below cumulative targets for personal health budgets as agreed with NHS England for 19/20, and we will refresh these trajectories for 2020/21.

Personal health budgets cumulative targets within NEL up until Q4 2019/20



Veterans

A veteran is someone who has served in the armed forces for at least one day, and there are 1,149 veterans in north east London. Across NEL we are committed to providing our veterans with the specialist care that they need, including high quality mental health support.

We will encourage our GPs and their teams to sign up to become a 'veteran-friendly' practice as part of the Veteran Aware Accreditation scheme to ensure that every veteran receives the best possible care from their GP, regardless of where they live, and to support GPs and practice teams to ensure that ex-forces are fully aware of the dedicated help available to them.

We will embed the six evidence-based components of the NHS Comprehensive Model for Personalised Care, and encouraged to work together with the individual to plan and deliver co-ordinated and personalised care that is considerate of the Armed Forces Covenant and the individual's military experiences. This is set out in a personalised care plan for the veteran, in addition to being supported to access dedicated services for veterans, to help ensure they are getting high quality care and support by military and civilian experts.

Summary

- In order to deliver the ambitions of our plan we need to ensure we have the right models in place to deliver care fit for the 21st century.
- Primary care will be at the heart of our approach with our 47 primary care networks the key building block to support service integration at a local level.
- We need to be able to manage demand for elective care services and we are working together through our elective care programme to make sure patients have access to the right advice, care and treatment in the most flexible way.
- We will continue to transform how we deliver urgent and emergency care building on the development of our enhanced NHS 111 Clinical Assessment Service, delivering designated urgent treatment centres across NEL and ensuring all hospital trusts provide same day emergency care by March 2020.
- We will work with partners to ensure best outcomes from clinical and surgical services, ensuring that providers are working together to deliver the best care.
- We will ensure our cancer programme continues to improve survival rates, address capacity challenges and improve services.
- We will ensure people have choice and control over their care through our personalisation programme, which will focus on increasing social prescribing, increasing uptake of personal health budgets and ensuring our care planning and support is centred around the individual.
- Underpinning all of this will be a commitment to embedding quality improvement to ensure we are continually working to improve our health and care services

CHAPTER 5- BETTER CARE, IMPROVED OUTCOMES

Chapter four of this document covered the areas where we need to transform the way health services are delivered to ensure they are fit for the 21st century. This involves developing a new model of primary care through the creation of primary care networks, radically improving the delivery of elective care services, and clinical and surgical services.

Chapter five focuses on the life courses – how we will make sure the people of north east London start well, live well and age well. This means looking at our diverse and growing population and how we can develop and provide care that meets their changing needs, and supports them to live long happy and healthy lives.

Maternity

We want to make sure that all babies born in north east London have the best possible start in life, and that their parents experience the best possible birth. Our growing population means over 28,000 of babies are born in north east London each year, and women can choose to give birth at home, in standalone or alongside midwife-led units, or in labour wards at four of our local hospitals.

A review of sector-wide demand and capacity indicates that maternity demand and complexity is likely to increase by 4.41% (approximately 1147 births) within the next five years, although this is not likely to be evenly distributed across our patch. The diversity of our population means that our expectant mothers have a range of medical problems with high rates of diabetes, obesity and deprivation, which in turn means increased demand for the specialist care to support them. We need to look at how we can balance demand and free up capacity in our hospital-based services so we can look after higher risk mothers. This will include reviewing at our model of care, and how we should use our midwife-led units in response to this growing demand.

Across north east London, we work as the East London Local Maternity System (ELLMS) on a number of initiatives setting out the vision for planning, design and safe delivery of maternity services; how women, babies and families are able to get the type of care they want; and how staff will be supported to deliver such care. Crucially, by 2025 we want to see a 50% reduction in stillbirths, neonatal and maternal deaths and serious brain injury. Our work is focusing on the following areas:

Continuity of carer (CoC)
Key to making sure that local mothers and babies have the best possible outcomes is ensuring as many as possible receive midwife-led continuity of carer to support a better start in life. The CoC priority is women who have been identified as most vulnerable and high risk and often these women are BAME. The ELLMS has worked together to agree a collective definition of these women and to make sure they are quickly identified and managed under the appropriate pathways. This definition has been embedded in the care model across all maternity sites to ensure that systems are in place to support reducing inequalities in care and variation in services.

In 2018/19, 21% of eligible women received full continuity of carer (target: 20%) By March 2020 we want 35% of eligible women to received full continuity of carer. In order to achieve this we will:

- Support Better Birth CoC leads at each Trust
- Implement new models of care specially for eligible women

By 2024, most eligible women will receive CoC from their midwife throughout pregnancy, labour and the postnatal period.

In north east London, BAME women are more likely to have poor outcomes when giving birth and CoC is a key initiative in addressing this. We are also reviewing and auditing maternity patient data in line with emerging national evidence to understand whether there are any additional cohorts that would benefit from being included in our CoC pathways as we scale up models of care.

Personalised care and choice
ELLMS is working together to make sure we deliver more choice and control for women and their families by providing a personalised approach to their maternity journey. We are prioritising delivering personalised care plans for more disadvantaged and vulnerable women and training staff involved in the care of vulnerable women to provide appropriate care planning.

In 2018/19, 72% of women had a personalised care plan (target: 50%)
By 2021, 80% of women will have a personalised care plan.

By March 2020, 100% of women will be offered information and choice on place of birth.

In 2018/19, 20.1% of women gave birth in a midwife-led unit (target: 20%). Improvements in choice and personalisation will mean that we expect this to increase further.

Standalone birthing units

There are two standalone birthing units in north east London – the Barking Community Birthing Centre in Upney and the Barkantine Birth Centre in the Isle of Dogs. Both are run by Barts Health NHS Trust and are for low risk women. They are midwife-led, which means that if women need care from a doctor, they are transferred by ambulance to hospital.

Activity at our standalone birthing units is lower than originally anticipated, and given the pressure on maternity services, particularly in the Queen's Hospital catchment, and the anticipated rise in births due to our population growth, we have agreed that our clinical senate will work with our ELLMS to review maternity capacity across the patch.

Maternal safety
To ensure improved maternal safety, we are supporting the establishment of networked maternal medicine services across London. We are fully engaged in the maternal and neonatal health safety collaborative programme to support improvement in the quality and safety of maternity and neonatal units and review evidence locally, by looking at audits, reviewing cases where a serious incident has occurred, sharing learning and understanding our changing population's demographics and the impact this has. We have:

- Developed specialist pre-term clinics
- Increased monitoring via national dataset
- Made sure we evaluate women's experiences and their outcomes on an ongoing basis
- investigate and learn from every Serious Incident (SI) we encounter.

We will fully implement the second version of the Saving Babies' Lives Care Bundle, which will help reduce perinatal mortality across England, by March 2020. This involves:

- Helping expectant mothers to stop smoking – working with Public Health to support smoking cessation programmes across maternity units to reduce variances in smoking rates and referring all identified women to smoking cessation programmes

- Consistent carbon monoxide monitoring at 6/34 weeks antenatally
- standardising use of the Perinatal Mortality Review Tool (PMRT) and sharing learning
- sharing learning from Serious Incidents (SIs) across NEL

We are committed to meeting the national ambition to halve the rate of stillbirths, neonatal deaths, maternal deaths and intrapartum brain injury by 2025, with a 20% reduction by 2020 and the diagram below shows we have exceeded this ambition.

Stillbirths, neonatal deaths and serious incidents in ELLMS

2017/18			2018/19			2019/20		
Stillbirths	Neonatal deaths	Serious incidents	Stillbirths	Neonatal deaths	Serious incidents	Stillbirths	Neonatal deaths	Serious incidents
149	61	64	135	54	63	26	11	11

We are tracking progress against the trajectories set in 2017/18 to halve mortality and morbidity rates in by 50% across all maternity services and consistently improves and sustain safety. This has been proactively managed within providers' unit's clinical governance frameworks.

In NEL we treat more women with complex maternal health needs, some of who do not live locally, and are transferred in to our maternity units due to the specialist care available: the Royal London Hospital is a tertiary centre that provides expertise of maternal care and obstetric care and the Homerton Hospital provides level 3 neonatal cots. This means that we may experience higher maternal morbidity and mortality rates due to complex medical and neonatal conditions that NEL sees.

We review every stillbirth and the PMRT has been adopted to support external review and shared learning. Health Safety Investigation Branch (HSIB) maternity investigations contribute to improving maternity safety and this approach will be a significant contributor to better outcomes. The Clinical Negligence Scheme for Trusts' ten point plan, which supports the delivery of safer maternity care, has been achieved by all units across east London.

We have committed to the establishment of Maternal Medical Centres (MMCs) across London, and will encourage the location of an MMC in north east London. MMCs will help reduce maternal morbidity and mortality and improve outcomes for women by helping to make sure the right care is provided at the right time, in the right place. The majority of women with complications during pregnancy will be managed by local maternity services, but there are some women where the rarity, complexity or facilities required by their condition mean they need to receive part or all of their care from specialist maternal medicine services

The development of MMCs is an opportunity to build on the work we are doing to improve the innovative and collaborative maternity offer and to shape a local system that actively promotes positive outcomes for women and babies. We believe delivering evidence based maternity interventions through the establishment of MMCs will maximise the effectiveness of ELLMS and play a key part in addressing longer term sustainability of this important work.

Postnatal care
We need to improve quality of postnatal care for all women. This includes increasing the accessibility of perinatal mental health services, offering training to community midwives to provide pre-conception care to vulnerable women (i.e. perinatal mental health, drug and substance misuse) and focusing on infant feeding.

Spotlight on: Perinatal Mental Health Services

Amara was referred to Perinatal Mental Health Services by her GP due to a history of postnatal depression after the birth of her first child. She was triaged and explained that her first labour had been traumatic. She had been induced due to pre-eclampsia and after a difficult delivery developed postnatal eclampsia and was sent for intensive care.

She described feeling unable to bond with her baby and saw her GP due to her low mood. She was prescribed antidepressants but did not take them for three months and became depressed again. She saw a private counsellor who allowed her to talk about how she was feeling and she was able to reconcile her feelings.

Through the assessment process staff identified Amara's concerns: the length of time it had taken for her to consider another child, her fears around delivery and her concerns about developing postnatal depression again. Through maternity liaison meetings with the hospital she became known to the specialist midwifery team who were able to support her.

Amara attended the clinical lead's clinic every six weeks through her pregnancy. These enabled her mental health to be reviewed and gave her space and time to reflect on her experiences in her last pregnancy.

The service was able to discuss strategies to address her fears and Amara was reviewed by a perinatal consultant psychiatrist to discuss prophylactic medications. Amara was also referred to parent infant psychotherapy to follow the service's birth trauma pathway so that she is able to therapeutically address her previous birth experience.

Data monitoring
We will support a staff training programme to ensure data is accurately entered in the maternity services data set that captures key information at each stage of the maternity care pathway including mother's demographics, booking appointments, admissions and re-admissions, screening tests, labour and delivery along with baby's demographics, admissions, diagnoses and screening tests. This will ensure that we improve quality and accuracy of maternity metrics by March 2020.

Implementation plan:

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Analyse two years of data to ensure that as a system, identification and management of eligible women is improving and how we can best focus our efforts to target care.	Improve holistic assessment framework for all women at bookings to make sure it includes a thorough medical, social and obstetric history. Embed CoC into our strategic commissioning and planning framework Further develop community CoC teams to target eligible women	Set baselines and improvement trajectories in line with year-on-year baselines and targets to ensure more eligible women are have CoC to close the gaps in care

	Develop CoC training for maternity staff	
Carry out quarterly audits of personalised care plans to ensure plans are personalised and co-produced. Audit at least 10% of births (randomised) and report back into individual Trust's Midwifery Improvement boards and LMS meetings as a standing item. Evaluate the feasibility of reviewing community sub-teams including different catchment areas to prioritise CoC throughout the maternal journey of postnatal care. Introduce the 'Perfect Ward' app at the Homerton's maternity service to collect data on the clinical environment, documentation, medicines management, patient experience and staff experience and identify learning.	Explore developing postnatal guidance in different languages. Move from handwritten postnatal community notes to digital notes. This will ensure the whole pathway of care is recorded electronically and provide robust data re CoC and Personalised Care Plans in the postnatal period once discharged home. Send monthly Friend and Family text messages to women at the four touchpoints identified in the maternity pathway Maternity Voice Partnerships will use 15 Steps Challenge for Maternity toolkit to collect qualitative information from the perspective of people who use maternity services 80% of maternity and neonatal staff will have completed two days of baby friendly initiative training Scope peer support and review community support for infant feeding Work towards UNICEF "Baby Friendly Initiative" (BFI) accreditation across ELLMS	Increase compliance with the completion of infant feeding checklist. Develop extended support services and referral pathways so that woman can access infant feeding support when additional support required.

Workforce
We cannot achieve our vision for maternity without the support of our dedicated and committed staff. We want to encourage skilled maternity staff to work in north east London to support the delivery of "Better Births".

To do this we have developed the 'East London Midwifery Recruitment and Retention Programme' a flexible career pathway which is individually tailored to midwives looking to gain specific clinical and managerial skills across a range of services. It also provides midwives with opportunities to work in a variety of settings and trusts across north east London. The success of this programme is reflected in our low vacancy rates across all units.

Our robust workforce programme will increase the job satisfaction among the maternity staff, will also offer opportunities for professional development therefore will decrease the high rate of staff turnover and increase staff retention rates.

Children and young people (0-25)

North east London has growing younger populations – 26% of our total population are 0-18 and 35% are 0-25. In Barking and Dagenham 41% of the population is 25 or under. Since 2016 we have had an active children and young people's programme, focussing on common priorities such as safeguarding, asthma and mental health. We also have a focus on reducing childhood obesity, which has been described in our prevention section in chapter 3.

Asthma: Developing best-practice across key pathway areas
We have developed an effective multi-agency network to support the development and improvement of asthma care, supported by partners across the partnership and the Healthy London Partnership. We plan to further expand the achievements of this network, and use it as a template for the transformation of our pathways and key conditions for our younger populations. Key developments for asthma over the LTP period will include:

- Reviewing and developing the case management model for asthma patients, ensuring effective distribution and impact of our nursing model of care.
- Improving the identification and management of high risk patient through improved communication across providers
- Developing effective integrated working across schools and community/specialist nurses via introducing MDT reviews.
- Enhancing asthma prevention through incorporating regular inhaler technique reviews via pharmacies. Also focusing on educating patients on self-care and preventing acute attacks.
- Upskilling school staff to enable them to deal with acute asthma attacks

Over the course of the long-term plan, we will align allergies with the asthma network. In addition, we will review expanding this successful model to other long-term condition pathways and areas as set out below:

- Asthma/allergies
- Diabetes
- Epilepsy
- Palliative care and bereavement services (including hospices)
- Patients with acute and complex health needs
- Paediatric critical care (via the North Thames Network)

Key principles of this networked and condition specific approach will be a focus on the patient/service user and alignment to best-practice pathways, as outlined by the Healthy London Partnership team and NICE guidelines. Our multi-professional approach will be strengthened by the involvement of local authorities and public health leads, as well as representation from across key NHS organisations across the partnership. We will involve our main community partners in this work, NELFT, ELFT and the Homerton and we will ensure community workforce developments are central to our transformation plans. Through a common benchmarking of community provision we will gain a better understanding of gaps in services and how the roles of nurses, paediatricians and GPs can be enhanced to support best-practice pathways out of hospital. A further key enabler across these areas will be the introduction of a digital health passport, a pilot scheme where data from all providers can be shared on a secure online platform, which can be viewed by primary, secondary, community

and other providers. This platform should support the proactive management of high-risk patients across key pathway areas.

SEND: A common approach to improvement
As we move into a new phase of work with our CYP programme we will harness the collective support across our NHS and local authority partners to make improvements to local services. We will begin with benchmarking and reviewing NHS services for patients with Special Education Needs and Disabilities (SEND patients). SEND children will benefit from earlier diagnosis and access to services, improving outcomes and quality of life. We will develop a common approach to benchmarking existing NHS services for these patients and agree best practice pathways. We will also move onto discussion with local authority and NHS representatives about key joint developments areas across health, public health, social care and education. This could include services such as health visiting, children's community nursing, and school nursing services. We will build upon the work from our asthma network in developing relationships with our education system to support training in the management of acute first aid for key long term conditions.

Improving transitions between childrens' and adult services and developing age-appropriate integrated care
In early 2019 we undertook a specific piece of work to see how we could improve the experience of health and care services for young people transitioning between children's and adults' services. They told us about inconsistent age-related cut-offs across different Trusts and service areas, and came up with many suggestions on how to make this transition process feel less intimidating and more personal for each younger person. We were keen to ensure that we prioritised this, and decided to broaden the scope of our north east London work to cover all ages up to 25, with a specific work stream focused on transitions. Over the course of 19/20 we will work up a programme to support improvements in this area, with a particular focus on clarifying roles and responsibilities for key clinical staff during the transition period. We will learn from STP areas, such as Yorkshire and Humber, which have prioritised a consistency of approach for addressing transition pathways. We will put together a range of common principles to guide work in this area, collaborating closely with our clinical senate, as well as acute care paediatricians, GPs and primary care networks and nursing and AHPs leads. We will also link closely with new redevelopment and capital works, such as the Whipps Cross redevelopment programme, to maximise opportunities for doing things differently on hospital wards for patients in their teenage and younger adult years. Finally we will maximise opportunities for new ways of working in primary care networks for patients during transition, exploring training of existing staff and development of new roles to address this issue.

In addition, we will explore the development of age-appropriate integrated care for children and young people, exploring the opportunities offered via Networks as they develop their service offers in line with the implementation of the new PCN contracts. During 2019/20 we will explore areas of innovation and best practice across NEL with regards to integrated care for children and young people, and will review how best to systematically develop these services across all areas over the course of this planning period. We will also further develop our social prescribing and personal health budgets offer for Children and Young people as part our personalisation programme.

Safeguarding for children and young people
We have developed our approach to safeguarding across north east London through joint meetings with all CCG safeguarding leads, to ensure we can resource and enact our statutory responsibilities. Where appropriate, we share resources across our systems for safeguarding, particularly utilising the expertise in our provider trusts. We ensure that all local safeguarding leads are strongly linked to local authorities and that risks are escalated

to governing bodies. In addition, we have a training programme in safeguarding for staff at all levels to ensure they are aware of their responsibilities in this area.

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Self-care programme implemented by pharmacies to support the asthma pathway work Training programme implemented across schools to support asthma acute exacerbation episodes Appraisal of case management and out of hospital model for asthma, informing intentions and developments for 20/21. Agreement to phased approach for implementation of network/pathway approach for CYP improvement programme Appraisal of approach via clinical senate for managing transitions Benchmarking of NHS services for SEND patients complete and recommendations for 20/21 compiled. Agreement on priority areas across health and social care for CYP (health visiting, children's community nursing, and school nursing services) Mainstreaming of We Can Talk mental health training programme across acute providers	Full implementation of CYP clinical pathway programme to include: - Asthma/allergies - Diabetes - Epilepsy - Palliative care and bereavement services (including hospices) - Patients with acute and complex health needs - Paediatric critical care (via the North Thames Network) Transition principles agreed and implemented across key NHS stakeholders Transition development programme agreed across acute and primary care/community, including a training programme for PCNs and the introduction of new roles where applicable Implementation of action plan complete following benchmarking of services provided for SEND patients Delivery of joint improvement programme complete for agreed CYP areas across health and social care Expansion of mental health training for CYP across schools and primary care providers	Demonstrable improvement in outcomes via the implementation of the CYP clinical pathway programme, particularly for asthma as the earliest implemented area Improvements in SEND pathway realised, leading to shorter waiting times and improved outcomes for cohort Further development of transition programme, expanding aligned approach across health and local authorities where beneficial

Children and young people's mental health

One in 10 children experience mental illness and half of all mental health conditions start before the age of fourteen. The high levels of deprivation locally greatly increases the likelihood of a child or young person developing an enduring mental illness. In north east London we want to make sure they receive 'world-class' mental health care, when and where they need it.

The NHS Long Term Plan committed that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.

Across north east London, we have made significant steps to improve mental health services for children and young people (CYP):

- Improving access to CYP services and committing to further investment and increased capacity in 2019/20
- Having a 'gold standard' highly specialist outreach crisis support (the Interact service, provided by NELFT). The team will see the CYP anywhere – in a park, cafe, home at school etc. - and the CYP will receive support from the same clinician throughout their time with the service. This is currently available in Waltham Forest and BHR with plans underway to extend this to City and Hackney, Tower Hamlets and Newham.
- Improving mental health support in schools: Tower Hamlets is a 'trailblazer' site for a national project to improve the mental health of children and young people by providing dedicated school Mental Health Support Teams (MHSTs), training to establish senior mental health leads and reduced waiting times for accessing Child and Adolescent Mental Health Service (CAMHS) treatment. This will help inform further work across NEL.
- Introducing the digital mental health support service Kooth which gives children and young people easy access to an online community of peers and a team of experienced counsellors. There are no waiting lists, no thresholds, no cost and complete anonymity. Kooth is available as anyone living in BHR and Waltham Forest. City and Hackney, Newham and Tower Hamlets now plan to implement this service.
- Reviewing mental health services data set (MHDS) submissions and working with providers in order to improve data quality and flow to the MHSDS, to ensure we delivers robust, comprehensive, nationally consistent and comparable person-based information for children and young people in contact with mental health services.
- Reviewing crisis pathways within local transformation plans and identifying gaps in service provision and ways to rectify this to ensure equitable service provision across NEL.
- Secured funding to reduce waiting times and waiting lists for emotional and behavioural pathways, and achieved the agreed reduction target.
- Developing a NEL-wide perinatal service for women across the two mental health trusts, with referrals taken from mental health services, primary care, midwives, obstetricians, local authority, health visiting, and universal services to give children the best start in life. In addition, women can self-refer in the NELFT catchment.

We are working to improve and strengthen the following areas:

- Consistent 24/7 CYP mental crisis support across NEL
- Improving access to eating disorder services so that 95% of those referred for assessment or treatment receive NICE-approved treatment within one week in urgent cases, and four weeks in routine/non-urgent cases in order to achieve the 95% national standard. In order to reach this target in a sustainable way, it will be reached by 20/21

- Aspire to all areas achieving the 34% CAMHS access target in 19/20
- Improve CAMHS productivity pathways so teams work more efficiently, and CYP have better outcomes and better access building on support from NHSE intensive support team
- Expand school and community based targeted and universal mental health offer (through the MHST trailblazer and whole school approach)
- Meet the four week waiting time target for children and young people who need specialist mental health services (as part of the 4 week wait times pilot)
- Expand/improve support for CYP in the justice system – build on the London ambition that no one accesses mental health treatment and care through A&E or the criminal justice system for want of an earlier intervention
- Continue to improve the data quality and flow to the mental health data set
- Improving mental health support for key providers involved in our CYP programme. We will continue with the implementation of our We Can Talk mental health training programme, ensuring that our main acute providers establish mental health support for 0-25 as mandatory training requirements for 2020/21. We will also explore opportunities for improvements to the mental health training for children and young people currently delivered to education (schools, primary/secondary - public/private) and to primary care (GPs, nurses, community). For schools, this could involve further upskilling of teachers, alongside school nurses and mental health trained support staff. We will also review the i-THRIVE framework for mental health for young people, and the potential for using this framework across our providers in north east London.

By the end of 2019/20 we will:

- Continue to improve access to mental health support for children and young people with increased numbers able to access to services for all residents.
- CYP workforce planning and risk mitigation. In line with the ambition to expand services, further investment has been made during 2019/20 enabling recruitment of more clinical staff and enhanced service developments.

By the end of 2020/21 we will:

- Scope and redesign mental health pathways for 0-25

Learning disabilities and Autism

It is estimated that people diagnosed with a learning disability account for 2.16% of our total population. In NEL, this is significantly lower at 0.54% of the population which equates to 11,340 people. However, we are aware that a number of people particularly with autism remain undiagnosed in NEL. People with a learning disability have a higher than average prevalence of a range of health conditions such as diabetes, asthma, epilepsy and a higher prevalence of mental health conditions than the general population. In line with this, research reports that those diagnosed with a learning disability experience poorer health care and inequalities compared to the general population.

In NEL, the average life expectancy for a person with a learning disability is 56 years (54 for females, 58 for males). This highlights a stark contrast against the general population life expectancy of 83 years.

We are committed to improving the care for people with a learning disability and autism and to ensuring that the causes of morbidity and preventable deaths are addressed.

Working in partnership, we will be able to share learning particularly regarding primary care incentive schemes to encourage results for this metric. In addition, we welcome the

introduction of the specific health checks for those with autism, as this will be an opportunity for all systems to collaborate on the pilot project and deliver against a set of agreed metrics.

There is also variation across NEL regarding the use of the STOMP-STAMP programmes to stop the overmedication of people with an LD, autism or both. Each system will be conducting regular reviews of LD and autism prescribing in line with STOMP/STAMP for all psychotropic medication for both adults and children.

NEL has been working collaboratively across systems on the Learning Disabilities Mortality Review Programme (LeDeR) and all partners have agreed for this to continue as a priority. Local systems will continue to complete LeDeR reviews and meet performance targets. This will provide an opportunity for shared learning and recommendations to reduce mortality rates and patient care.

We recognise that we must improve our understanding of the needs of people with a learning disability across NEL and to ensure that all local healthcare providers are aware of LD and autism and make reasonable adjustments to support people.

At present, all NHS partners have access to learning disability and autism training for staff and organisations and this is often part of the current commissioned contracts. Within the next five years, we expect all primary care colleagues to be trained in LD and autism and within each partnering organisation, the development of LD and autism champions in settings.

The ELHCP will work in partnership with specialised commissioning to ensure that hearing and dental checks are available to children and young people with a learning disability or autism both in residential schools. This will be done at a NEL level.

In line with our plans for system based working, we are committed to working with all partnering organisations, including local authority to ensure that packages of care are developed jointly between services and that packages meets the holistic needs of those with a learning disability or autism. We will ensure that packages support people throughout the whole diagnostic process and that contract service specifications support this deliverable.

We are committed to ensuring that all children, young people and adults with a learning disability, autism or both receive personalised care, which allows them to live a fulfilling life. We want to ensure that people and carers can choose care around their individual needs and preferences.

Across NEL, we will support the development of models of care which support community based care. We will ensure that across all partners, there is access to community crisis care to reduce preventable admissions to inpatient services. We will continue to explore forensic support and other service models, including new respite and accommodation. In collaboration with our partnering organisations, we will develop specialist community teams for children and young people and models of care to allow people with an LD and autism to stay within community care as opposed to institutional care.

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Appointment of SRO to lead the programme. Development of a NEL learning disability and autism programme board.	There are varying levels in the uptake of the annual health checks in primary care and these range from 52% - 82% in the last year. In order to increase the	A ‘digital flag’ will be within patient records to ensure that staff know if patients have an LD or autism. We will support the rollout of the digital flag together with our IT teams. This will ensure

Undertake gap analysis of provision of care to identify unmet need, gaps in care and local health inequalities. Increased engagement with people with lived experience and their families in checking the quality of care, support and treatment. Identification of planned reductions for inpatient usage and beds.	number of those accessing health checks In line with NHSE guidance, we will make sure that all primary care providers complete annual health checks for 75% of people aged over 14 years. Linking with the ELHCP workforce programme, we will build on national workforce initiatives such as the return to practice programmes to ensure that LD and autism is prioritised in workforce training.	that people receive care around their needs and that services can be personalised around their needs. Children and young people with an LD, autism or both will have a designated keyworker. This will be implemented via the development and rollout of a NEL risk register for children with LD, autism or both. Keyworker support will also be available provided to children and young people who are inpatients or who are at risk of being admitted to hospital. We will ensure that it is also extended to the most vulnerable children including those who face multiple vulnerabilities. Redesign of our learning disability and autism services to ensure that is a reduction in inpatient activity for those patients. In order to support this, the ELHCP has committed to ensuring the provision and rollout of personalisation and personal health budgets across NEL. The ELHCP will be supporting systems to work towards increasing the PHBs uptake and embedding this requirement within current service specifications and contracts. All learning disability and autism care commissioned across NEL must meet the NHS and NICE guidelines. We will support local systems to implement the 12 point discharge plan through the transforming care programme. This will ensure that patients with long lengths of stays are actively being moved

		towards discharge with plans and processes in place to allow them to receive personalised care.

Major long term conditions

Improving the health and care management of people with long term conditions is a key aspiration of the NHS and north east London care providers. The unique demographics of NEL correlate directly to the prevalence of LTCs within the local population. Diabetes is six times more common amongst the south Asian community and we have estimated numbers of 129,000 people living with diabetes across NEL. Also linked to the same local population are increased risks in developing cardiovascular disease, it is fifty percent higher in first generation South Asians in comparison to the White European population. London experiences 9,400 premature deaths per year due to poor air quality and the project population increase will also lead to further rises in traffic and the potential for increased respiratory related disease. Stroke modelling across NEL has derived that approximately one in every five people who have atrial fibrillation will go on to develop a stroke and it is estimated that 15,500 have atrial fibrillation in NEL. According to the latest data, overall new HIV diagnoses in London have declined 42% between 2015 and 2018 (from 2,585 down to 1,504), however London is still a high prevalence area and continued efforts need to be focused and the recognition of HIV as a LTC is part of this journey.

The recognition that better management of those with long term conditions within the community promotes stable conditions and an improved quality of life, especially where deprived communities are concerned. However, a ‘one size fits all’ approach would likely have limited success and defining what constitutes best practice in terms of GP, primary, community and social care provider roles has yet to be defined. NEL are committed to developing health and care for those affected by cardiovascular disease (CVD), stroke, respiratory disease, diabetes and HIV.

NEL and Place Level Overview of Key Statistics

Statistic	National Average	Regional Average	NEL Average	Barking & Dagenham	City & Hackney	Havering	Newham	Redbridge	Tower Hamlets	Waltham Forest
A&E Attendances per 100,000 weighted population (Q4 17/18) *(Time Series Chart for STP)*	37,409	53,672	51,540	47,930	55,809	32,309	65,271	45,019	64,176	51,823
Total Referrals per 100,000 weighted population (Q4 17/18) *(Time Series Chart for STP)*	34,136	45,343	47,108	45,383	44,018	42,609	47,836	52,116	47,623	50,065
Total Outpatients per 100,000 weighted population (Q4 17/18) *(Time Series Chart for STP)*	93,750	122,134	101,777	87,840	102,138	91,770	106,314	109,278	104,710	108,399
Total Bed Days per 100,000 weighted population (Q4 17/18) *(Time Series Chart for STP)*	55,194	53,587	49,363	46,391	48,747	53,962	42,615	52,994	43,682	56,081
FTE GPs per 100,000 *(GPFV Dashboard Dec18)*	0.58	n/a	0.51	0.43	0.59	0.52	0.46	0.47	0.58	0.48
GPs Aged Over 55 *(STP Datapack 17/18)*	-	22%	25.6%	29%	19.7%	28.6%	29.9%	28.1%	18.8%	29%
Deprivation Score *(IMD 2015)*	21.8	n/a	31.4	34.6	35.3	31	32.9	20.2	35.7	30.2
Child Obesity *(Fingertips, 2017/18)*	34.3%	37.7%	-	44.5%	40.2%	37.3%	43.2%	40.2%	42.1%	40.4%
Diabetes Diagnostic Rate *(Fingertips, 2018)*	78%	71.4%	-	85.9%	61.2%	76.5%	80.9%	79.2%	80.5%	65.8%
TB Incidence (per 100,000) *(Fingertips, 2018)*	9.2	21.9	27.7	27.4	22.3	10.4	49.3	35.4	23.4	25.7
Depression Prevalence *(Fingertips, 2017/18)*	9.88%		6.92%	6.47%	9.64%	7,46%	5.37%	5.52%	7.23%	6.76%

Key	
NEL Indicator	Worst
	2nd Worst
	3rd Worst
	Middle
	3rd Best
	2nd Best
	Best

Key	
NEL Average	Worse than national average
	Better than national average

1

Cardiovascular disease (CVD)

Our ambition is to develop interventions over the next five years that will improve prevention reducing cardiovascular risk and mortality in our population, by maximising detection and treatment of cardiovascular risk factors and minimising variation in care. For example within the London borough of Newham one GP practice was able to identify 82% of the patients predicted to be hypertensive compared to another practice identifying just 23%. Coronary heart disease (CHD) across NEL in comparison to the national five lowest CCGs show further disparity and scope for development. CHD elective bed days for Tower Hamlets and City and Hackney are 55% and 50% higher with NEL overall having a 6,758 patient higher prevalence of CHD. Non-elective CHD spend also shows differences to the lowest five CCGs with Newham, Tower Hamlets and Redbridge being £959k, £750k and £712k higher respectively.

CVD prevention in north east London is established within localities and our aspiration is to scale up recognised pockets of excellence across the footprint, standardise pathways and minimise variation. Reducing CVD mortality as NEL has 105 more deaths per annum compared with the lowest five CCGs. We want to build upon the East London Prevention (ELoPE) group as the nucleus around which a NEL-wide collaboration can develop and deliver the ambitions set out by the LTP, the national CVD prevention programme and align to the London Vision. Currently, ELoPE is an umbrella group that develops and facilitates CVD prevention strategies in the large NEL population served by the Bart's Heart Centre. The group brings together cardiologists, diabetologists, primary care physicians, public health doctors, cardiovascular specialist nurses and pharmacists; and has developed partnerships with the British Heart Foundation, NHS England, Public Health England, NICE, Park Run and Sugar Smart among others.

Several of the ELoPE projects map directly to the LTP CVD ambitions. For example, the schools programme responds to the pledge to halve childhood obesity by 2030 while the Make Every Contact Count campaign speaks to the detection and treatment of risk factors. This is an important opportunity to address some of the long-standing health inequalities in CVD prevention across NEL that our clinicians have repeatedly drawn attention to. Prevention initiatives should in turn translate into reduced costs for secondary care; as per the model hospital Barts Health spend on cardiology is £98.24m higher than its peer median (£26.28m); whilst BHRUT's cardiology spend is £14.01m, £3.5m higher than the national median.

Based on collective clinical and research-based observations, local needs and in line with the LTP the following CVD initiatives have been proposed:

1. Risk Factor detection and treatment
Detection and treatment of hypertension, dyslipidaemia and AF remains central to CVD prevention and is amenable to the data-driven approach proposed by the local clinical effectiveness group (CEG). This approach has been applied successfully in Redbridge for detection of patients with AF receiving inadequate treatment. The inclusion of practice-based pharmacists has allowed delivery of treatment without adding to the workload of primary care clinicians and is a model that could be extended across the sector. This also overlaps and covers the ambitions for the London Vision for CVD Prevention.

2. Familial Hypercholesterolaemia (FH)
Undetected high cholesterol in families poses a significant risk of premature death yet is easily treated. The NEL area has historically been underserved for FH and

needs a co-ordinated area-wide service. ELoPE has initiated a nascent service and this now needs expansion with inclusion of community case-findings strategies to maximise clinical effectiveness. This system wide collaboration is an ideal opportunity to address this long standing need.

3. Preventative treatment – optimising CVD medicines
The NEL CEG's Triple Aim programme is also supported by ELoPE, and is an important means to standardise care and optimise treatment of key risk factors and medication usage. Focusing on those who are undertreated or not on the correct medication for 1) first line drugs for high blood pressure, 2) statins at the correct doses and 3) minimising treatment induced bleeding.

4. Secondary CVD Prevention after Myocardial Infarction and Stroke
These patients are high risk following discharge into the community. We know that less than half attend cardiac rehabilitation and less than a quarter are on guideline recommended treatments. ELoPE is working to standardise care pathways and optimise medications in this group, using conventional and digital approaches. This work would benefit from this collaboration as it requires a sector wide approach.

The ELoPE group is already engaged in developing these and a number of other projects as part of a comprehensive and outward facing prevention strategy for the population served by the Barts Heart Centre. There is ambition to facilitate the expansion of these initiatives across all of north east London reducing unwarranted variation in health and care for both the individual and local population. The development of a NEL wide CVD prevention steering group is currently underway and aims to be in place by April 2020.

Stroke

We will develop a system approach to the stroke pathway across NEL ensuring equality of care via local clinical leadership developing robust plans to capitalise on best practice and providing coverage by integrated stroke delivery networks. This would also include configuring a coordinated service delivered by BHRUT and Bart's Health for a 24/7 service that provides mechanical thrombectomy, significantly reducing the need for rehab and improving the patient's quality of life. This will also release much needed stroke beds, reduce lengths of stay and reduce ambulatory care, providing efficient stroke care across NEL.

The BHRUT hyper acute stroke unit (HASU) currently provides mechanical thrombectomy. Barts Health also provide similar services from their HASU and the collective ambition is for both to offer a 24/7 service before April 2021.

We also want greater coordination of care between acute stroke units and utilisation of beds while also establishing greater uniformity in stroke care pathways for prevention, outpatients services and rehabilitation.

The BHR local system is currently developing an integrated stroke delivery network (ISDN) to be set up by April 2020. It will focus on developing the following key areas to improve stroke prevention and care:

- AF pathway for stroke prevention
- consolidating two rehab units into one (previously consulted on)
- reviewing and develop an enhanced Early Supported Discharge services
- developing the way services collaborate as one integrated system

As part of their long term conditions contract with primary care providers, City and Hackney have implemented, parameters that include indicators aimed at reducing risk of stroke or

having a further stroke. These include pulse checks, annual CVD risk checks, blood pressure measures, statin medication reviews, smoking cessation support and post stroke annual reviews. Going forward scoping and development is being directed toward embedding a prevention focus across all integrated care workstreams with plans in development for 2019/2020.

By April 2020 a NEL wide stroke strategic steering group will be established with representation to include primary care, acute stroke specialist services, community health services, LAS and the voluntary sector. Envisaged key themes will be to establish a uniform atrial fibrillation (AF) pathway for stroke prevention, the coordination of a 24/7 mechanical thrombectomy service and redesigning stroke rehabilitation elements which would benefit from a NEL wide uniform pathway e.g. early supported discharge and community rehabilitation. There will also be a links with the wider LTCs (diabetes, CVD and respiratory) and the health of care of those patients with respect to their specific needs regards stroke prevention and care. The remit of the steering group will be to also identify and apply for capital investment which may be required for stroke transformation.

Respiratory disease

Respiratory disease is one of the main health issues affecting local people, this is due to high levels of air pollution, social deprivation, poor housing and a high incidence of smoking across the population. Hospital admissions for lung disease have risen over the past seven years at three times the rate of all admissions generally and remain a major factor in winter pressures on the NHS. We are committed to reducing the number of people who are diagnosed with a respiratory disease. Whilst also improving both the identification and treatment support for those who have been diagnosed. We will strive to reduce variation in outcomes across boroughs and transform our outcomes to ensure better patient care.

One current issue across NEL is the late detection and diagnosis of respiratory problems; frequently these conditions are diagnosed during a hospital admission. We are committed to ensuring that all partner organisations provide timely and accurate diagnosis of respiratory diseases especially COPD. This will be done via the implementation of a case finding approach across NEL. Once patients are identified, we will ensure timely access to spirometry to gain a diagnosis. We are committed to building on the existing NHS Right Care programme to reduce variation in the quality of spirometry testing across NEL. We will support the diagnosis of respiratory conditions in primary care. This will be done via ensuring that staff are trained and accredited to provide the specialist input required to interpret results. This ensures that patients can be diagnosed out of hospital and will have access to earlier treatment and improved outcomes.

Community acquired pneumonia is a leading cause of admission to hospital and these admissions have risen by 35% since 2013. Across NEL it will be ensured that each organisation who identifies patients with respiratory disease will be advised on self-care techniques to reduce the likelihood of acquiring pneumonia. Risk scoring for deteriorating patients will also be implemented to ensure that patients receive timely interventions to reduce the risk of hospital admission. In addition, those patients identified with community acquired pneumonia in emergency departments will be supported to be cared for safely out of hospital by receiving nurse-led supported discharge services.

Pulmonary rehabilitation services are an important part of the management and health maintenance of people with chronic respiratory disease. 90% of patients who complete the programme experience improved exercise capacity and increased quality of life. However, it is currently only offered to 13% of eligible COPD patients, with a focus on those with more severe COPD. Commitments are being made to maximise referrals to pulmonary

rehabilitation provision for patients, particularly for those who are socio-economically disadvantaged. The National Pulmonary Audit standards advises that services should endeavour to enrol 85% of those referred to pulmonary rehabilitation within 90 days and should aim for patient completion rates of 70% or more following assessment for pulmonary rehabilitation. To increase access to pulmonary rehabilitation, a population-management approach will be used in primary care to find eligible patients from existing COPD registers who have not previously been referred to rehabilitation. New models of providing rehabilitation to those with mild COPD, including digital tools, will be offered to provide support to a wider group of patients with rehabilitation and self-management support.

By 2023/4, the expectation across NEL is that 60% of people will start pulmonary rehabilitation and of those people referred, 90% will complete pulmonary rehabilitation. The expansion of pulmonary rehabilitation will improve care and provide better outcomes whilst reducing respiratory related non-elective activity.

Incorrect use of medications contributes to poorer health outcomes and increased risk of exacerbations and on occasions unnecessary admissions to hospitals. Across NEL, the programme will be prioritising medicines optimisation for inhaler use and additional medicines. This will ensure that people with respiratory disease use the right medication, thus improving health outcomes. We will ensure that pharmacists and patients are trained and informed on the correct use of inhalers and that pharmacists will undertake medicine reviews. In order to achieve this we will map workforce that supports medicine optimisation across NEL and implement and secure ongoing training.

By April 2020 we will establish a NEL-wide strategic respiratory steering group that will oversee the development and implementation of national, regional and local programmes related to respiratory health. This includes aligning to the vision for London and Mayor of London's priorities such as targets for air pollution.

HIV

Treatment means that people living with HIV have a normal life-expectancy but are still required to take medication on a daily basis and as such in NEL we consider HIV long-term condition. 337 people were diagnosed with HIV in north east London in 2018.

This will become especially important with the ageing cohort of people living with HIV whose healthcare needs, co-morbidities, and polypharmacy will increase. One in three (30 per cent) people living with HIV in the UK is aged 50 or over. By 2028, this is projected to rise to more than half (54 per cent). Currently, 40% of people living with HIV accessing HIV care in London is over the age of 50.

The HIV voluntary organisations across London have been a core part of shaping the London HIV response. Supporting people living with HIV to manage their condition well, and address the significant needs including mental health and emotional well-being; condition self- management; sex and relationships needs; and social needs – as they relate to, affect and are affected by HIV. In light of this they will be included in healthcare planning across London.

There is a need to ensure that HIV health outcomes, prevention, testing and treatment are integrated with wider healthcare. Four key priority areas to improve London HIV health outcomes have been identified by PLWH in London:

- London Fast Track Cities Initiative. London recently signed up to the Fast Track Cities Initiative (FCTI). London has achieved the FCTI 90:90:90 targets and was the

first city globally to achieve the 95:95:95 ambition. The next step will be reaching the final 5% undiagnosed, ending all HIV transmissions, ending HIV stigma, ending preventable deaths from HIV-related causes, as well as improving the health, quality of life and well-being of people living with HIV in the capital.

- Opt-out testing in A&E. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV infection, and people diagnosed late are likely to have been living with an undiagnosed HIV infection for at least 3 to 5 years. Despite this, between 2015-2017, 35% of new diagnoses in London were made at a late stage of HIV infection.

- Mental health services/drug services. People living with HIV (PLWH) are twice as likely to experience mental health issues compared to the general population. Voluntary sector services can offer mental health provision in a non-clinical setting that acts as a complement to NHS generic and specialist mental health provision. Mental health support for people living with HIV begins with peer support, which is highly effective at supporting emotional well-being and condition self-management. Similarly, recreational drug use amongst PLWH has been shown to be higher than in the general population. Problematic drug use can significantly impact upon mental health and wellbeing.

- HIV as a long term condition. HIV is now considered a long-term condition. Treatment means that people living with HIV have a normal life-expectancy but are still required to take medication on a daily basis. Despite this shift in the way we discuss HIV, HIV is still not considered alongside other major long-term conditions as explicitly as it should be across the healthcare system. HIV should be especially considered in this context when planning healthcare in high prevalence areas such as London.

Diabetes

Diabetes is a leading cause of premature mortality with over 22,000 additional deaths nationally each year. We aim to improve the clinical outcomes of people living with diabetes and therefore reduce the associated complications of diabetes including renal disease, amputation and sight loss.

Our diverse population correlates to high levels of diabetes; type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common among people of African and African-Caribbean origin. Diabetes prevalence is also known to be higher in areas experiencing deprivation. People living in the 20% most deprived neighbourhoods in England are 56% more likely to have diabetes than those living in the least deprived areas. This may relate to spend on drugs for diabetes per 1000 weighted population as BHR (26,220) and Newham (29,468) are both higher than the national average (171998). Waltham Forest has 5.9% higher diabetes registered patients across all GPs than the national average.

The risk of developing Type 2 diabetes also increases by up to ten times in people with a BMI of more than 30 and in relation to other LTCs, people with diabetes are two to three times more likely to have a stroke compared to those without the condition. Diabetes is a progressive disease with Type 2 diabetes patients dying on average five years earlier and Type 1 diabetes patients dying 10 years earlier, than those living without the condition. It is estimated that 16% of deaths in adults in Tower Hamlets are attributable to diabetes higher compared to 12% nationally. NEL are committed to meeting the LTP commitments for both Type 1 and 2 diabetes.

There are currently over 129,000 people living with diabetes in NEL, so preventing and managing diabetes is a clinical priority within NEL for the following reasons:

- **Population diversity** - NEL has large communities that have particularly high incidences of diabetes.
- **Deprivation** - Several boroughs across NEL are known to have some of the highest levels of poverty and deprivation indicators in England.
- **Increasing incidences** - Newham has highest rates of Type 2 diabetes in London for both 18-39 and 65-79 year olds. For 18-39 year olds, B&D is second, for 65-79 year olds, TH is second in London.

Our ambition is to prevent or delay 'high risk' patients from developing Type 2 diabetes and improve clinical outcomes for people living with diabetes across NEL. To achieve this we have developed a programme of work covering the following initiatives:

- Targeting NDH patients. There are 50,000 people living with Non-Diabetic Hypoglycaemia (NDH) also referred to as pre-diabetes, which means raised blood sugar levels that are not in the diabetic range. The rates of NDH are high in NEL when compared to London and national rates. Thus far 14,245 people have been referred to the national diabetes prevention programme (NDPP). In line with the LTP, spaces for the programme will be more than doubled over the next three years. NEL will commission services to support the identification and onward referral of people with NDH into the NDPP. We will achieve 50% in line with national uptake of patients referred for the programme attending the sessions by 2020/21. We will engage with people living with NDH to understand and overcome the barriers to accessing diabetes prevention programmes.

- By 2020/21 we will have commissioned primary care services that support the systematic review of people who are at 'high risk' of developing diabetes, with a digital option available to patients accessing the NDPP by 2020/21.The NEL diabetes diagnostic rate is 65.8% which is lower than the 71.4% of London.

- Building on a pilot in City and Hackney; we will look to become a test bed site for low calorie diets to support the remission of diabetes, which if successful will be rolled out across NEL in 2020/21

- We will scope to integrate where possible the national diabetes prevention programme with local tier 1 / 2 services and other prevention services such as smoking cessation.

Improving outcomes and avoiding complications
We will commission services to support the systematic review of people living with diabetes with pilots to support new models of care e.g. group consultations and online consultations as piloted at Newham Hospital.

Utilisation of digital technologies will ensure that patients are supported to self- care / self-management ensuring that those who meet eligibility criteria and will benefit from flash glucose monitors by 2020.

We will work with partners to expand the use of digital technologies to support people living with Type 2 to self-manage their condition e.g. through the roll out of 'HeLP diabetes' by 2020 and other online platforms.

We will develop diabetes models of care that are personalised and based around the patient and there is access to specialist teams where required, in all care settings, following the examples in Havering, Tower Hamlets and Newham.

Working with diabetes teams we will review further related prevention targets, such as premature heart disease which is a related complication derived from diabetes.

Learning from the models of care in Tower Hamlets and Newham we look at approaches to improving outcomes for people living with diabetes through an MDT approach.

Building on the current programme of work we will continue to work with Diabetes UK, London Diabetes Clinical Network and local engagement teams continue to work with people living with diabetes to understand the outcomes that matter to them and design services that personalise care.

LTC implementation plan

	By the end of 2019/20	**By the end of 2020/21**	**By the end of 2021/22**
CVD	Establish NEL wide steering group Defined and initiated programmes targeting priority areas	Via single CCG across NEL, ensure uniform services commissioned in relation to prevention and treatment.	Continued delivery of programmes in regards to scaling up best practice and new models of care across NEL
Stroke	Establish NEL wide steering group Defined and initiated programmes targeting priority areas	Via single CCG across NEL, ensure uniform services commissioned in relation to prevention and treatment.	Continued delivery of programmes in regards to scaling up best practice and new models of care across NEL
Respiratory disease	Establish NEL wide steering group Defined and initiated programmes targeting priority areas	Via single CCG across NEL, ensure uniform services commissioned in relation to prevention and treatment.	Continued delivery of programmes in regards to scaling up best practice and new models of care across NEL
HIV	Determine resource and NEL networks able to deliver on the London key priorities	Delivered on programmes related to metrics and targets.	Monitoring and improving upon established models of care.
Diabetes	Establish NEL wide steering group Defined and initiated programmes targeting priority areas	Commissioning of services which aid diabetes prevention. Build on national and local programmes.	Establishing services and monitoring progress.

Adults' mental health

People with mental health problems have often experienced health and care services that treated their minds and bodies separately and didn't take a whole body approach to care. This is starting to change, with understanding of, and attitudes towards mental health improving, as people realise this is very common - one in four people experience a mental health problem.

The national Long Term Plan reaffirmed the commitment to putting mental health care on a level footing with physical health services. Across north east London we are committed to meeting the ambition of parity of esteem between mental and physical health for children, young people, adults and older people. As well as access to good quality mental health care wherever they are seen in the NHS, we want people with mental health issues to live good lives – to be employed, have good relationships, somewhere comfortable to live, and to feel part of their community.

The Long Term Plan made a renewed commitment to improve and widen access to adults needing mental health support and offer the fastest expansion in mental health services in the NHS's history. In north east London we are working to achieve this through:

Improved Access to Psychological Therapies (IAPT)
IAPT services provide evidence based therapies for people with anxiety and depression. IAPT has been able to achieve significant improvements in the way mild to moderate anxiety and depression is treated within the NHS. Services across north east London have achieved consistently high recovery rates (against national standards) and/or significant improvement in the current year.

We have increased access to low intensity online therapy through our NEL-wide contract with Silver Cloud digital mental health platform. This includes over 30 self-help and therapeutic programmes via a library of engaging programmes is accessible via a flexible, user-friendly online platform. Residents are able to self-refer online in all local boroughs. Further investment in 2019/20 and beyond will expand IAPT services to include psychological treatments for more people with physical long term conditions such as diabetes, COPD and Irritable Bowel Syndrome.

We also have the following work underway:

- Working together to increase online access to IAPT, including a coordinated marketing approach across NEL
- Working together to recruit staff to work in psychological therapies so that each area has enough staff to provide a high quality responsive service.
- Promoting online therapy – increasing awareness and uptake of this approach
- A focus on improving staff retention in Barking and Dagenham in particular to address its low access rate.

Employment support and recovery
Employment is vital for maintaining good mental health and people with mental health problems are traditionally more likely to become unemployed and can often find it harder to regain employment.

The IPS (Individual Placement and Support) service supports people with severe mental health difficulties into employment. It involves intensive, individual support, a rapid job search followed by placement in paid employment, and time-unlimited in-work support for both the employee and the employer. Research showed IPS clients were twice as likely to

gain employment and worked for significantly longer and individuals who gained employment had reduced hospitalisation rates.

Currently, IPS is available in Tower Hamlets and Newham and national transformation funding has enabled the launch of IPS services in Waltham Forest, City and Hackney and Redbridge. Havering and Barking and Dagenham are looking at transforming their employment services to meet IPS. During 2019/20 validated IPS services will be available in all areas of north east London resulting in significant increase in the number of people with long term mental health problems being supported into paid employment.

We are also exploring:

- Meeting the agreed targets to expand services following successful awards of transformation funding in 2018/19 and 2019/20
- How we can work with DWP, the voluntary sector and other mental health services such as recovery colleges
- How we can ensure all NEL IPS services rate as good or higher on the IPS fidelity scale
- Involving people with people with lived experience and exploring co-production opportunities
- Developing a common framework and an easy guide of what IPS is
- Identifying and developing training for clinicians
- Widening the scope of the service to include people with learning disabilities and people with physical impairments
- How we can integrate roles across our two mental health trust to ensure services are resourced and staff gain a breadth of experience

Mental health support for people with HIV

People living with HIV are twice as likely to experience mental health issues compared to the general population. Mental health support for people living with HIV begins with peer support, which is highly effective at supporting emotional well-being and condition self-management. We will ensure HIV-related peer support is available across NEL.

We commit to explicitly improving the integration of HIV services with mental health within the wider context of committing to improving the integration of mental and physical healthcare. This includes utilising the new primary care networks to ensure integrated pathways are in place.

Severe mental illness (SMI) health checks

In NEL there are 20,629 people with SMI eligible to receive an annual physical health check. The aspiration is that 60% of these - 12,377 people - should receive the check. In 2018/19, 42.8% of people did, which suggests that we are making good progress towards meeting the 60% target.

We will address the complex needs of those living with severe and enduring mental illness in the community, and when they are need of crisis and acute care by redesigning mental health services with partners and communities to deliver the vision set out in the Long Term Plan and the Mental Health Act Review.

Community mental health service transformation

The enhanced primary care service (EPCS) is aimed at people, who are a low enough risk and stable enough to be treated in primary care but whose needs are such that they require an additional level of support. The service is focused on people with severe and/or enduring

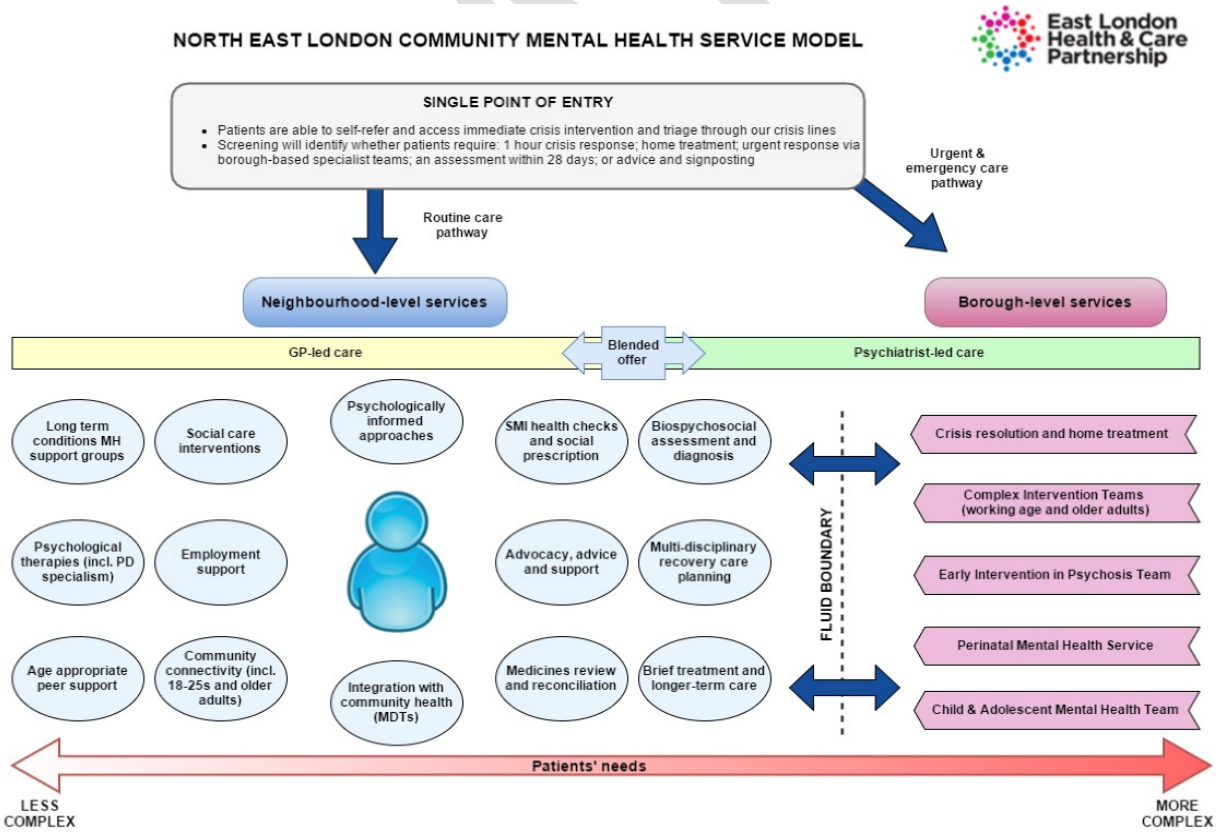
mental health conditions including anxiety, depression, psychotic disorders and personality disorders. It is not aimed at people with milder or common mental health problems.

We already have mature EPCS for people with SMI in City and Hackney, Tower Hamlets and Newham which have promoted better outcomes and reduced caseloads in secondary care by 19%. Following a successful bid for wave 1 community mental health transformation funding this year, we are excited to be launching our programme of redesign in 2019/20. Waltham Forest, Barking and Dagenham, Havering and Redbridge have already begun developing their approach to EPCS for people with SMI in readiness for the wider transformation piece to come; and we are committed to sharing knowledge and expertise as a partnership to facilitate this process.

The vision for community mental health services centres on the following:

- Dissolved barriers between 'primary' and 'secondary' mental health services
- Support dictated by complexity of need rather than diagnosis
- Population health management approaches; addressing the totality of residents' needs in a multi-disciplinary and multi-agency way
- Services that are embedded within neighbourhoods / communities; enriched by community assets and peer support
- Differentiated offers for 18-25s, older adults, and people with personality disorders
- Moving towards a referral-less approach to assessment and support

Some of our early design principles are illustrated below:



Creating centres of excellence for adults mental health inpatient services

We are considering how to best deliver inpatient mental health services for adults living in City and Hackney, Tower Hamlets and Newham. These services provide a safe and therapeutic environment for people with acute mental health problems. We want to make

sure that people who need inpatient services have the very best support and treatment, in the very best of environments that deliver:

- improved service user experience and outcomes
- improved staff experience
- community neighbourhood and crisis services that will support people to remain at home, through more preventative integrated services, including with primary and social care
- an inpatient clinical model that promotes high-quality treatment and support that addresses peoples mental, physical and psychosocial needs, and supports them to return home as quickly as possible
- an improved and modern therapeutic environment
- operational effectiveness and value.

This work is at an early stage but it is anticipated options will include developing a single site for inpatient services for adults of working age and for older adults. Any proposals would require engagement and or consultation, as appropriate.

24/7 adult crisis resolution and home treatment teams
All CCGs within NEL have committed to achieving 100% coverage of 24/7 adult crisis resolution and home treatment teams by the end of 2019/20. With support from NHS England transformation funding, all areas will achieve this by 2020/21.

NEL community crisis care offer
The ambition for mental health crisis care is to provide a truly 24/7 response that is equitable across all areas and to all age groups by 2023/34. Our crisis response will seek to de-escalate crises by responding proactively to patient needs sooner, and closer to home, enabling treatment in the least restrictive environment possible.

Mental Health liaison services
There are 24/7 psychiatric liaison services operating in all acute hospitals in the NEL. City and Hackney and WEL already deliver 'gold standard' CORE 24-compliant psychiatric liaison services, with the BHR local system due to deliver CORE-24 compliance in 2020/21.

While we want to reduce demand on A&E departments through our crisis resolution and home treatment teams and the development of community crisis alternatives, we will also seek to ensure that residents of all ages with both physical and mental health needs who require treatment in an acute setting receive the wraparound support they need from CORE 24-compliant psychiatric liaison services.

Complementary crisis care alternatives
We already commission crisis alternatives in City and Hackney and Tower Hamlets, and as part of NHS England crisis transformation funding, voluntary and community sector-run 'crisis cafes' will be expanded in City and Hackney, Tower Hamlets and Newham in 2019/20. In BHR and Waltham Forest, alternatives such as street triage are already in place, with transformation funding being used to expand the crisis offer for residents with a personality disorder diagnosis in 2019/20.

Health based places of safety and NHS 111
Residents across NEL now have access to 24/7 mental health crisis lines that can accept and facilitate warm transfers from NHS 111. We are working together to stop using ED as a health-based Place of Safety, with the expansion of dedicated Section 136 suites planned for 2019/20 and 2020/21.

We will build on the successes of our 24/7 mental health crisis lines, which successfully enable warm transfers from NHS 111, and will increase support to the London Ambulance and Metropolitan Police Services through the development of street triage, Serenity Integrated Mentoring and ambulance call centre co-location.

By remodelling our approach to community mental health services, as well as our crisis offer, we hope to provide early help to residents in such a way that reduces the need for Mental Health Act assessments and detentions. However, should local people enter crisis and require detention under s136, our health-based Places of Safety will represent fit-for-purpose spaces that promote dignity; staffed by a dedicated and well-trained workforce.

Suicide prevention

138 people died by suicide in north east London in 2017. This is the highest rate of the five London systems. Suicide is the leading cause of death for men under 50 and deprivation is a major factor in male suicide, increasing the odds of taking your life by 10 times, compared with the suicide risk of more affluent men. We are looking to address this by:

- Developing a zero suicide prevention plan for inpatients across NEL, working towards a 10% reduction in suicides by 2020/21.
- Providing bereavement support services for those affected by suicides
- Delivering suicide prevention training for schools, colleges and all staff
- Working closely with partners, the Samaritans, Thrive LDN, the community and voluntary sector and Met Police
- Identifying training needs and promoting training a (i.e. ASSIST, SafeTalk, Mental Health First Aid) across NEL for frontline staff and education sector colleagues to support suicide prevention awareness.
- Partnership working with Thrive LDN and testing out its information sharing hub to learn from best practice elsewhere.

We will build on the successes of our mental health programme to deliver these ambitions, utilising our robust assurance framework to monitor and ensure progress against key milestones.

Implementation plan

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Online therapy increases access rates by at least 2% in each CCG All areas have established Long Term Conditions IAPT services Investment and staffing trajectory to reach 30% IAPT access rate signed off between CCGs and providers NEL suicide prevention strategy agreed All Five Year Forward View mental health standards	All CCGs will have 24/7 CRHTTs which meet NHSE high fidelity standards All acute hospitals in NEL will have psychiatric liaison services in place that meet CORE 24 standards develop a crisis alternative in Newham, and expand the offer in Tower Hamlets and City and Hackney All health-based Places of Safety staff are well-trained and dedicated workforce (distinct from the teams staffing our MH acute services)	The Mental Health Steering Group will work closely with London Ambulance Service colleagues to translate national implementation guidance, seeking guidance from local A&E Delivery Boards and Crisis Concordat Partnership Boards on the appropriate model of delivery Develop crisis alternatives in Waltham Forest and BHR Support local systems to build confidence and capacity within primary care to enable the integration of community mental health

achieved across all service areas.	IAPT Staff recruitment and retention drive leads to full staff complement for BHR All CCGs delivering their 60% health check targets, which will set us up to meet the increasing trajectories up to 2023/24. All IPS posts to be filled with the team at full complement Integrate IPS with other MH services i.e. recovery college, job centres	services with primary care networks' MDTs by 2023/24.

Investing in and prioritising mental health

The NHS Long Term Plan commits to grow investment in mental health services faster than the overall NHS budget, creating a new ring-fenced local investment fund worth at least £2.3 billion a year by 2023/24 with a new commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.

London priorities for mental health
London wants to collectively set, and hold itself to, ambitious long term outcomes. To ensure success the steps to deliver them would be developed with partners over a five to ten year horizon. They include:

- Individuals and communities are enabled to help themselves and know when and where to seek support
- No child starts school unable to learn or leaves school unable to work
- Everyone living with complex and severe mental illness has the same life expectancy as their fellow citizens
- Everyone living with a long term physical health condition receives support for their mental health
- No one accesses mental health treatment and care through A&E or the criminal justice system for want of an earlier intervention
- No one takes their own life

Medicines optimisation

The national expenditure on medicines in the NHS is £16 billion a year. The medicines spend in NEL is more than £200million a year. This is a considerable proportion of NHS budget and is one of the most significant intervention in managing patients' health.

Between 5-10% of all hospital admissions are medicines related. Two thirds of medicines related hospital admissions are preventable. Reports suggest that up to 50% of people do not use their medicines as intended. A 2010 report estimated that the national figure for pharmaceutical waste was £300million with half of this being potentially avoidable.

Medicines optimisation looks at the value which medicines deliver, making sure they are clinically-effective and cost-effective. It is about ensuring people get the right choice of medicines, at the right time, and are engaged in the process by their clinical team.
The goal of medicines optimisation is to help patients to:

- improve their outcomes;
- take their medicines correctly;
- avoid taking unnecessary medicines;
- reduce wastage of medicines;
- and improve medicines safety.

This presents us with both the opportunity and obligation to ensure best use of NHS resources to sustain healthy living, prevent disease and improve clinical outcomes for local people.

Our objectives
The Medicines Optimisation and Pharmacy Transformation (MOPT) programme will work with all health and social care professionals to ensure:

- Promotion of healthy living and disease prevention
- Easy access to health and medicines advice to empower residents and patients to control their own health or disease, reducing health inequalities
- Consistently provide best in class management pathways across all providers, reducing unwarranted variation in health outcomes
- Improve medicines safety systems and reduce the risk of medicines errors
- Optimise use of NHS resources on medicines including commissioning best value medicines
- Reduce waste by promoting better patient understanding of their medicines and support healthcare professionals to implement processes and systems to enable this e.g. adherence clinics.

We will do this by developing the pharmacy profession, using technology and population level data, as well as increasing awareness of medicines optimisation and medicines safety in the wider health and social sector.

Polypharmacy and overprescribing
Polypharmacy is described as the concurrent use of multiple medicines by one individual and is common in the elderly or those with multiple morbidities. Polypharmacy can be problematic where there is an increased risk of medicines interactions or adverse reactions.

We will support the national review of problematic polypharmacy and overprescribing and lead on implementing changes across the system and local level to ensure patients are prescribed medicines appropriately. Appropriate polypharmacy can extend life expectancy and improve quality of life.

This will be achieved through:

- Training and development for all health and social care staff including support workers involved in the medicines optimisation pathway
- Patient centred structured medication reviews as required to be delivered in primary care networks.
- De-prescribe in consultation with the patient where clinically appropriate e.g. medicines of limited clinical value
- Improved use of technology including electronic prescribing and shared access to records by staff and patients
- Roll out of the Transfer of Care of Medicines (TCAM) programme piloted in Waltham Forest CCG and Whipps Cross Hospital whereby community pharmacists receive referrals from Acute Trust pharmacists for patients with a high need for pharmacist support post discharge. Elsewhere this programme has been shown to reduce hospital readmissions.
- Medicines reconciliation as recommended in the NICE guidance and part of the new community pharmacy contract.
- Integration with community health services and local authority staff supporting patients post discharge or living independently in their homes.
- Development of pharmacists working in care homes as evidenced in BHR CCGs.

Improving clinical outcomes

The MOPT programme board will develop integrated medicines care pathways which recognise that patients may have multiple conditions (physical and mental) rather than single disease conditions and need to move between primary and secondary care seamlessly. Pharmacists are recognised experts in medicines and are ideally placed across the system to support these pathways. Community health service teams will be trained to identify patients who may benefit from a review e.g. falls risk. Patients with multi-morbidity could have all their long-term conditions reviewed in one visit by a clinical team responsible for co-ordinating their care.

To deliver this we will establish a NEL Medicines Optimisation Policy, Formulary and Pathway group which will produce evidence based guidance for implementation across the system. This group will be supported by the work of the Regional Medicines Optimisation groups and NICE. Having one clinical group informing medicines use will reduce variation and inequity in practice.

Better value medicines programme (BVMP)

We will implement the national BVMP to help the NHS deliver better value from the annual spend on medicines in NEL. This programme identifies medicines including biosimilars which through improved procurement, contracting and agreed pathways can release savings on the cost of these medicines to the NHS. Following a number of national consultations there are also local agreements to implement policies to reduce the use of medicines of limited clinical effectiveness.

Improving patient safety

We will deliver the new national patient safety improvement programme including the medicines safety improvement programme which aims to increase the safety of those areas of medication use currently considered highest risk and address the continuing threat of antimicrobial resistance. At a system level we will provide technology and tools to reduce risk but we recognise patient safety is improved locally at the point of care.

We will do this by:

- Implementing new technologies including electronic prescribing and medicines administration (EPMA) (implemented in Homerton since July 2015, BHRUT local approval awaiting national funding, Barts from 2020), automated dispensing (robots / cabinets), Scan4 Safety/ closed loop medicines administration systems, electronic prescribing risk and safety evaluation (ePRaSE), Health Information Exchange (Homerton and C&H, Newham, TH and WF), clinical decision support tools, artificial intelligence to aid triaging and appropriate patient access to clinical records to facilitate shared decision making.
- Implementation of programmes in primary care which identify patients at risk of medicines issues e.g. Pincer, eclipse or similar local Clinical Effectiveness Group trigger tools
- Support contractually aligned patient safety quality indicators in general practice and community pharmacist e.g. review of sodium valproate use in pregnancy, and lithium monitoring.

Access to NHS mail, summary care records and electronic prescription services (eps) will enable community pharmacists to assess relevant clinical information quickly and communicate more easily with patients and other healthcare professionals. NHS111, GPs and hospitals will be able to refer patients directly to local pharmacies through the new community pharmacy consultation service which will relieve the pressures on GPs, speed up hospital discharge and ensure patients have the support they need once they arrive home.

Technological advances in dispensing systems e.g. robots enable community pharmacists to provide additional clinical services.

Antimicrobial resistance (AMR)
Reducing antimicrobial resistance is a WHO priority. AMR is already estimated to contribute on average to over 2,000 deaths annually and cost the NHS approximately £95 million each year in the UK. The National Action Plan aims to reduce AMR in the UK and has a specific focus on reducing healthcare-associated infection (HCAI), in particular aiming to reduce healthcare-associated Gram-negative blood stream infections (GNBSIs) by 50% by 2023/24.

NEL MOPT has an established multidisciplinary multisector AMR group which has developed system wide antimicrobial guidelines. This group and the SRO will continue to prioritise this work across all the providers.

Developing One Pharmacy Workforce
The Long Term Plan highlights the importance of pharmacists and pharmacy technician across all healthcare sectors. We need more pharmacists and pharmacy technicians to develop one pharmacy workforce to work across all healthcare sectors. Having one pharmacy workforce will enable staff to share their expertise and spread learning, provide seamless care for patients wherever they present and offer improved access to patients. Pharmacists are qualified recognised experts in medicines use and we will develop the profession to enable pharmacists and pharmacy technicians to work at the top of their competence, conduct research and deliver more patient facing clinical services in the places most appropriate for patients.

We will adopt a cross sector pre-registration and post graduate training programme for pharmacy professionals to include development to consultant level pharmacists. This professional development model will include coaching, mentoring and action learning sets, building on the experience of developing the physicians' assistant role in WF.

The national Pharmacy Integration Fund helped pilot the role of pharmacists working in new clinical environments in NEL. We will continue to develop these roles in care homes, urgent care and primary care networks.

Community pharmacists will provide expertise to enable patients to manage minor illnesses and live healthier lives. Consultant pharmacists will provide specialist services across the system and support training to expand expertise in others.

We will support integration of community and primary care pharmacists and pharmacy technicians in the primary care networks. We will facilitate professional development within PCNs. We will support models where pharmacy professionals can work flexibly within joint management structures but across different settings. We will provide professional and clinical leadership through the senior pharmacy support in the ICS.

Prevention

We will work with public health, community pharmacies and patient groups to promote awareness of self-care as well as increase access to prevention services including vaccination programmes. We will engage with patients to ensure they know where to access information about maintaining optimal health and advice on minor illnesses by promoting the community pharmacy services.

Community pharmacies are now expected to be the first port of call for minor illness and health advice in England as part of the new contract. It expects all community pharmacies to be a “Healthy Living Pharmacy” by April 2020. This will require all community pharmacies to have trained health champions in place to deliver interventions on key issues such as smoking and weight management as well as providing wellbeing and self-care advice, and signposting people to other relevant services.

Testbed community pharmacy sites may also be used to test a range of prevention and detection programmes e.g. detecting undiagnosed cardiovascular disease. As the testbed programmes report on the outcomes we will assess how they may benefit local residents.

Ageing well

NEL has a growing ageing population with 281,550 people aged over 60. It is projected that by 2035, there will be 408,772 people aged 60 and over and in line with an ageing population, there will be an increase in the number of people living with long term conditions and the number of those living with dementia is set to double by 2030. This will inevitably increase the number of people needing NHS care and also the intensity of support they require.

NEL is a diverse population with a high number of ethnic groups which presents increased risk of some priority health conditions. Black and South Asian people have a higher risk of developing diabetes and Black men are at a higher risk of developing prostate cancer. Across NEL, we will ensure that all ethnic groups have access to prevention measures to maintain a healthy and independent life for as long as possible. In order to complete this work, we will be ensuring that all partners agree to prioritise our ageing well agenda and that funding will be used to focus on:

- Working in collaboration with health and social care to ensure that people are supported to age well.
- We will prevent poor outcomes through active ageing
- Ensuring that quality of care is improved within our existing acute and community services. We will also develop new services in collaboration with our partners based on patient needs.

We will develop our own ageing well programme which will meet bi-monthly with all partners. BHR partners have been working on improving care for our ageing population. They have introduced an ageing well strategy and have improved the provision of services for patients which have mostly focused on reducing social isolation and loneliness through the promotion of local ageing well groups. We will build on this and across NEL, will benchmark ageing well services currently in place to understand the provision and from this, our funding for the programme will focus on the following work:

Anticipatory care
Our focus is on ensuring that people age well and maintain a healthy life that our ageing population maintain good physical and mental health, through healthy diet, promotion of regular exercise, tackling loneliness and early identification of health problems and treatment. We will be focusing on the implementation of anticipatory care for complex patients at risk of unwarranted health outcomes in NEL. We will target support towards older people with moderate frailty as well as people of all ages living with multiple comorbidities. Anticipatory care will be delivered jointly by primary and community services and we will ensure integrated teams are in place along with social care and the voluntary sector. The programme will be delivered through primary care networks and multi-disciplinary teams and will use the electronic frailty index and clinical judgement. This will identify older people living with frailty and their carers who are at risk of adverse health outcomes and provide them with tailored and personalised care. Through the implementation of anticipatory care, patients will be supported to stay well and at home for as long as possible.

Community care
Our key priority to ensure people age well is to improve our offer of primary and community based care. In 2018,164,673 patients aged 60 and over in NEL received care in hospital and this can often be due to no diagnosis or poor management of a health condition. Within the ageing well programme we will transform out of hospital care and fully integrate community based care to ensure that people receive their care out of hospital. In order to complete this, we will focus on the provision of primary care as part of the primary care network delivery. We will ensure for those patients aged 60 and over they will receive a health check in

primary care to identify or discuss their health, ageing well and any long term conditions they may have. This will ensure patients receive care personalised to their needs and allow people to be identified who may benefit from the personalisation programme in NEL. To ensure that all primary care staff have a knowledge of ageing well and how to support patients, the programme will ensure that we help to tackle the workforce challenges in community services. This will be done through supporting the workforce programme on primary care and ensuring that all primary care staff are offered training and support to provide personalised care.

In terms of reducing the number of people conveyed to hospital we will ensure that we support primary care to develop enhanced health in care homes to identify and treat long term conditions effectively. Our intention is to reduce avoidable emergency admissions, ambulance conveyances and sub-optimal medication regimes. In order to do this we will involve the delivery of enhanced primary care/speciality support in care homes, regular multi-disciplinary team resident reviews, aligned with rehabilitation services where these are provided, and support timely access to out of hours support and end of life care. We will also deliver improved crisis response within two hours, and ensure that reablement is provided within two days in our community health services.

Collaboratively with our partners, the programme will ensure that we improve the responsiveness of our community health services. In line with the ageing population we anticipate that there will be an increase in the need and use of community services. In order to do this we will develop local ageing well service specifications in line with our partners. We will work in collaboration with our voluntary sector partners, such as Age UK who have existing commissioned contracts across NEL and work with supporting patients and carers in the community. The programme is also committed to reducing variation across boroughs and ensuring that no matter where a person lives, they will receive care which supports them to age well. We will develop a cross sector engagement strategy to find out the needs and wants of our population and will be identifying and addressing issues which prevent cross-organisational and integrated team working.

Improving dementia care
As the population ages, dementia has become one of the most important health issues nationally and the number of those living with dementia is set to double by 2030. Dementia and dementia care costs the health and social care economy more than those for cancer, heart disease and stroke combined. The aim of our programme on dementia will be to raise the profile and importance of dementia care and support and to ensure that services in the community meet the needs of our patients with dementia and their carers.

Within NEL, Havering has one of the highest proportions of older people in London. The population of over 65s is expected to increase by 26% over the next 15 years; and that of the 85+ by 46% over the same period. Many ageing people with dementia and also be living with other long-term conditions, as the risk factors for the main types of dementia are similar to those that result in conditions such as cardiovascular disease (CVD) and diabetes. People with a learning disability are at an increased risk of developing dementia compared with the general population, with a significantly increased risk for people with Down's Syndrome and at an earlier age.

Our priorities to improve dementia care across NEL include:

- Raising awareness, prevention and identification
- Access to timely assessment and diagnosis
- Supporting people to live well with dementia
- Ensuring that those with dementia are supported during their end of life

To achieve our priorities, by 2023 we will:

- Ensure that the workforce are trained to develop and acquire appropriate competencies and skills in dementia, ageing well and end of life care.
- Ensure that care packages also meet the needs of the caregiver, including their health and wellbeing.
- Co-design service specifications and delivery with service users and carers, providers, and commissioners.
- Provide access to high quality evidence based services in the community including advice, information, housing support and leisure activities which enable people with dementia and their carers to live well.
- Commission and provide a range of high quality evidence based services which are accessible, integrated and in line with local levels of need, both now and in the future. This will need to take full account of the predicted increases in levels of need and demand on services.
- Develop robust data and reporting systems for services across the dementia pathway, in order to fully understand the impact of the predicted increase in demand and its impact on services.
- Develop a cohesive and whole system approach to the commissioning of dementia services via partnership working with health, public health and social care.
- Continued awareness raising across the community, through the Dementia Action Alliance, which is the favoured model for the development of 'dementia friendly' communities and is effective in reducing stigma.

Spotlight on: Homerton's integrated independence team

Based at Homerton Hospital, City and Hackney CCG's Integrated Independence Team takes an innovative, multi-disciplinary approach to helping people maintain their independence.

The team is a fully integrated service which is jointly funded through health and social care budgets. The service works in collaboration with the local authority, primary care and other statutory and voluntary organisations to ensure people get the care they need to stay as independent as possible for as long as possible.

It is a multidisciplinary team comprised of physiotherapists, occupational therapists, speech and language therapists, social workers, consultant geriatricians in intermediate care, nurses, OT technicians, psychotherapists, independence assistants and coordinators.

The integrated independence team sets rehabilitation goals and works towards these via bespoke treatment plans and also by providing practical support, such as help washing and getting dressed. It also addresses longer term concerns like social isolation through partnership working with established services in Hackney and the City.

The multi-disciplinary team works with GPs and district nurses as well as emergency departments to make sure that unnecessary admissions to hospital are avoided and people get the care they need to keep them out of hospital.

It aims to:

- avoid hospital admissions and attendances at A&E
- provide early, supported discharge from hospital wards
- support patients to work towards attainment of rehabilitation goals when at home
- prevent early admission to long term residential care

The team has a clinically-led single point of access and initial screening determines the urgency of the patient's needs and if necessary, a rapid response team can be mobilised. These rapid response clinicians focus on seeing patients usually within an hour in A&E and within four hours on ACU/general wards.

Around 350 people are referred to the integrated independence team each month. These come from GPs, hospitals, social services, community mental health teams and others. London Ambulance Service is also able to refer direct to the team if necessary.

Care support packages are put in place where relevant at the point of discharge from the service to ensure care continues as needed in the longer term, with the team working with the voluntary sector and charities such as Age UK.

Children's end of life care

There is approximately 120 children and young people deaths across NEL each year with most children dying in hospital care due to poor levels of community palliative support for children's care. Across NEL, we are committed to improving children's palliative and end of life care, ensuring that children receive personalised end of life care and are supported to die in a setting of their choice.

In order to facilitate this, the ELHCP will develop a cross borough 'hospice at home' care model in partnership with hospices, health providers, local authorities and the community and voluntary sector. This will ensure that children have the opportunity to die at home while receiving personalised care.

Our key priorities are:

1. **Ensuring that children and young people with a life-limiting condition are recognised and have a central role in decision-making and care planning**

The ELHCP programme will ensure that systems will identify children and young people who have a life limiting condition and will ensure that they are placed on the children and young people's palliative care register. We will develop and ensure that there is a standard identification tool in use. We are making sure that patients (where appropriate) and carers are involved in their care decisions. We will continue to ensure that the children's advanced planning process is adopted and used by all partners aligning with the NICE children's and young people end of life and bereavement standards. This will ensure that patients and carers have time to understand their diagnosis and an opportunity to choose their care around their personal needs.

In 2019, all partners in NEL agreed to implement and use Co-ordinate My Care (CMC) as a shared information record. We will continue to support partners with the implementation process and will be promoting the rollout of 'My CMC' for patients and carers to ensure their care amend their care plans based on their needs. This will ensure that patients and carers are an integral part of the care planning process and that they will receive better care.

2. **Extending community outreach care to support more children and young people to die at home**

In 2020, we will focus on developing a cross borough hospice at home model to support children to die at home and for carers to receive the support they need. We will be developing this model in collaboration with our local hospices, Haven House and Richard House. We realise that our hospices are keen to provide outreach support into the

community and as a programme we will support this model of care. Within the next five years, we will be actively seeking funding to ensure the delivery of this model and it is expected that we will bid for funding from NHSE when details become available.

3. Improving support when a child dies

In 2020, we will be standardising the support and information which a carer receives when a child dies. Bereavement support is currently provided to varying levels across NEL, our focus in 2020 will be to ensure that all systems are providing bereavement support in line with the NHSE guidance on 'Information for Families'. In terms of improving our services, the programme will support partner organisations to ensure the collection of meaningful feedback and learning of their experiences during their child's death. In order to do this, the child bereavement experience by the Healthy London Partnership measure will be used by all systems across NEL. This will ensure that information is collected on how EOL services have performed, improve service outcomes and share learning across collaborating organisations.

4. Improving support for children who have been bereaved

From 2020, the programme will ensure that all local children who have been bereaved in will receive information and support within 10 days of bereavement. We will ensure that all children are offered timely access to counselling and support and will continue to work in partnership with our voluntary organisations, including Child Bereavement UK.

Adults' end of life care

Statistics show that across NEL, the majority of patients die in hospital with four of our boroughs having the highest rates of hospital deaths. In addition, 36.6% of end of life patients die in their usual place of residence, compared to the England average of 46.8%. In NEL, patients can choose to die in hospital, hospices or at home and we must ensure that all palliative patients have access to personalised care for patients and carers to support people to die in their place of choice.

Our five year plan will be to commission new personalised models of care, which are focused on integration and coordination, and responsiveness of local services. We want to achieve equity in choice in access to services and equity in outcomes so that regardless of borough in NEL, each patient will have access to the same level of care. This will ensure that patients have a better experience in death and are supported to die with dignity, respect and with their care preferences met. During 2020, we will be focusing on increasing community awareness of death and dying and hard to reach groups.

To support the improvement of end of life services; the ELHCP end of life programme brings together the views of NHS England, providers, commissioners, local authorities, local hospices, community and voluntary sectors. Together we developed a programme plan priorities for end of life and these align with national policies.

Implementation plan

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
We will review existing evidence across all local authorities and CCGs to identify any gaps in information that will support improvement. Develop mechanism for gathering additional data required	We will ensure that all partners promote and support the provision of personalised care for patients and carers. We will ensure that all providers will have access to referring to the programme and where	We will continue to deliver a new model of training to ensure that all staff who work with end of life patients and carers are competent in providing person centred end of life care and that

including patient and carer experience, which is standardised across NEL. We will focus on developing a data pack for each CCG area baselining current position in terms of end of life care with agreed improvement trajectories. The programme will have increased focus on case finding and ensuring that patients identified as palliative are recorded on GP palliative care registers. We expect by 2020, that 65% of patients who died in each borough had been identified by GPs, placed on the GP palliative care register and had a CMC record completed. We will continue to rollout CMC in CCGs and providers across NEL, including the rollout of my CMC for patients and carers. Within five years' time, we expect all of provider organisations to have access to and use CMC to ensure that care records are accessed and that care provided meets their patients' needs and wishes. We will continue to identify opportunities for additional training and develop a case for education and training funding. This will be done in collaboration with colleagues in workforce, Health Education England and St Joseph's Hospice who are developing our training model. In 2019, we will continue to commission models across NEL and to share learning with supports (C&H, WEL	appropriate we will fund personalised care through personal health budgets. By 2021, we will introduce KPIs into all community and voluntary contracts to ensure that we identify patients and carers eligible for the personalisation programme. Patients will receive access to personalised care planning and recording of preferences involving family members appropriately. We will be seeking to standardise primary care contracts to focus on increasing the number of patients on the palliative care register, increasing CMC plans, delivery of CMC and learning from the Quality and Outcomes Framework. We will continue with the development of the EMIS screening tool in primary care to identify those patients not identified and placed on the palliative care register. With the tool, it will allow patients to be identified as palliative earlier and ensure that they receive personalised care around their needs. In 2020, we will implement this across NEL and within five years, working in collaboration with NHSE we expect this to be used as a national end of life identification tool. Working in partnership with primary and secondary care, we will ensure better discharges from hospital and less readmissions within 90 days of hospital discharge. We will complete an audit process in 2020 to understand issues with	competencies are maintained/refreshed. By 2022, we aim to have a cross borough Hospice at Home model across the WEL system to ensure that resources such as staffing can be shared across boroughs. This will ensure an appropriate use of resources and reduce the amount of funding required whilst ensuring that patients receive personalised care and are supported to die at home.

and BHR) system and service redesign and improvements. This will involve all relevant sectors including health, social care and the voluntary sector. We will be working to standardise the approach to collecting carer feedback for end of life services across NEL. We will use this information to identify service issues and work collaboratively with our partners to address these and improve patient care. This will be completed by end of 2019 with rollout of the agreed model in 2020.	discharge from hospital and will develop guidelines to ensure effective discharges. Working in partnership with primary and secondary care, we will ensure better discharges from hospital and less readmissions within 90 days of hospital discharge. We will be completing an audit process in 2020 to understand issues with discharge from hospital and will develop guidelines to ensure effective discharges. In 2021, we will be hosting a cross borough end of life event for the public to be informed of local services and improvements they want from end of life care across NEL. We will work together with our partnering organisations and community groups to ensure representation. We will develop a directory of services in NEL to ensure patients and carers have access to support and advice.	

Summary

- Across our programmes of work we want to ensure our local population has the best start in life and through the course of their lives are supported to live well and age well.
- Through our maternity programme we will ensure mothers have continuity of carer, improve maternal safety and continue to grow our workforce to support our plans.
- Our children and young people's programme will focus on asthma care, mental health and improving the transition from children to adults services.
- We are committed to improving the care for people with a learning disability and autism and to ensuring that the causes of morbidity and preventable deaths are addressed.
- We will work together across the system to improve the health and care management of people with long term conditions with programmes of work in place for CVD, stroke, respiratory disease, HIV, diabetes and adults mental health.
- We will ensure our local population are supported to age well and with our partners will focus on anticipatory care, community care and improving dementia care.
- We will ensure our local population, both children and adults are supported at end of life and receive personalised support and are able to die in a setting of their choice.

CHAPTER 6 - ENABLERS

To support the delivery of our plan we need to ensure a number of enabling programmes are in place. By enablers we mean programmes which cut across all of our work and are integral to the successful delivery of our priorities. These programmes are workforce, digital, estates and research and innovation.

- To deliver the best care and support for our local populations we need a robust workforce and we will continue to build on our work to grow our workforce, drawing on our local talent across north east London. We will also continue to support our current workforce and ensure the NHS is the best place to work. We will also continue to develop a culture of positive leadership and work across our system to develop a new operating model for workforce to support the development of our integrated care system.

- Digital transformation will be at the heart of our work and across north east London we have already made great progress as a partnership on areas such as shared care records. We will continue to work together to ensure digital technology is in place to support our local population to access health and care services efficiently.

- Our estates programme will focus on delivering modern, fit for purpose infrastructure in order to meet the capacity challenges we face from a growing population. Our priorities include using capital investment to deliver a health and wellbeing centre in Havering and continuing to make the case for the redevelopment of Whipps Cross Hospital.

- It is an exciting time for research and innovation in north east London. The development of a Life Sciences centre at Whitechapel will place us at the forefront of innovation and ensure we are utilising research to enhance the care and support we provide to our local population. Our programme of work will also ensure we are increasing participation in research and fostering evidence based practice and innovation.

Workforce and culture change

To achieve the ambitions proposed in this plan we need a workforce equipped with the right skills, values and behaviours to deliver our health and care services. Additionally to meet the rising demand as our population grows and their health needs become more complex we will need both more people working in our local health and care system but also for our staff to work in in different ways.

Our workforce programme is crucial to the success of our ambitions and the following chapter outlines how we will meet the expectations of the national NHS Interim People Plan and ensure we have a workforce fit for the future, equipped to deliver our vision and provide quality care and support to our local residents and that reflects the diversity of our local population.

Over the next five years as we move towards an integrated care system for north east London and transforming commissioning by 2021 our workforce will need to adapt and change to work in an integrated way in flexible roles which require a wider skillset.

An effective ICS will require a culture of high staff satisfaction across NEL, where people are encouraged to stay within the system and feel empowered to grow and develop in to their

roles. Strong and effective leadership will be key and we need to ensure there is a leadership plan in place, which supports and develop our leaders. It is also essential that we are diverse and inclusive and improve our approach to the workforce, race and equality standard (WRES).

Ultimately, we want to ensure we have a modern health and care system, which is robust and equipped to manage the needs of a growing and ageing population. Central to this will be a multi-professional integrated workforce-delivering primary and community health and care services.

In order to meet this challenge we will need to develop these roles and market them effectively in order to attract people to north east London and to ensure more of our local population are able to work within our services.

In line with the NHS Interim People Plan, we need to do the following:

1. Support our current staff and make the NHS the best place to work
2. Improve the leadership culture
3. Address shortages in nursing
4. Deliver 21st century care
5. Develop a new operating model for workforce

What have we achieved so far?
As a system we have been working together collectively since 2016 to address the challenge of recruitment and retention. This has involved the following:

- We have set up infrastructure and governance to help us work together as a system. This includes the London Workforce Action Board (LWAB) which brings together employer HR directors, professional leads, primary and social care representatives, higher education leads, Health Education England and local workforce transformation leads, the ELHCP executive which comprises system leaders across the partnership and the NEL HR Directors Forum which brings together HR directors from providers and commissioning.
- Marketing NEL as a place to live, train and work has been a big focus and we have developed a health and social care careers website focused on encouraging people to consider a career with us. This website includes information on why north east London is a great place to live and work offering different pathways depending on where you are in your career e.g. just starting out, already working in health and care or looking for a career change and links to job vacancies.
- We have held careers fairs across NEL to promote the benefits of a career in health and care, these have focused specifically on GP recruitment. We have also engaged closely with schools and colleges to promote opportunities in health and social care.
- We launched a Physician Associate Course with 70 percent of students now employed in roles in local GP surgeries and hospitals. We have a further 70 students on the course who will graduate in 2020/21.
- Working with NHS England and NHS Professionals we are developing a model for a nursing bank in general practice to increase capacity and retention.
- Recruiting GPs through the international recruitment scheme, with six in place so far.

Each of our clinical workstreams are already working to address workforce challenges within their area as follows:

Maternity – flexible career development has been established with midwives able to rotate around roles and organisations. This is aimed at attracting potential midwives to come to north east London and develop their career across the maternity system. We also have the

ELHCP maternity passport, which allows midwives training and development to be standardised and recognised in north east London.

Urgent and emergency care – working with partners across providers, primary care and London Ambulance Service to build opportunities for improved working across urgent care.

Prevention – building on the opportunity to embed and develop social prescribing roles across care networks and the voluntary sector.

Cancer – developing solutions for a flexible and adaptable cancer workforce for the Early Diagnostic Centre and developing career pathways across the system.

Mental health – we have focused on building the workforce up to ensure patients have improved access to mental health services across north east London and that appropriate interventions are available through IAPT and Children and Young People services.

Children and young people – to review and identify priorities for developing the workforce to support interventions for children with long term conditions.

Social care – developing career pathways for clinical apprentice roles in care settings, and explore development of clinical skills champions in care linking and publicising opportunities through our careers and marketing platforms.

Developing career pathways for care workers through supporting apprenticeships and explore the development of clinical skills champions in care which enable progression into nursing associate or nursing roles. Publicising these opportunities through our careers and marketing platforms.

Primary care - embedding new roles in primary care as part of the primary care network development, underpinned by robust general practitioner and general practice nurse recruitment and retention programmes.

Support primary care networks to include and involve all roles involved in personalised support in their development. Support social prescribers and care workers to work with primary care colleagues to develop new ways of working together and to embed intra-professional learning.

Our ongoing challenges and gaps
As we work towards enhancing and growing our workforce to meet the needs of a new operating model we need to tackle the following challenges and gaps:

- An expected high population growth and subsequent demand for services mean we need to ensure we both grow our workforce and retain them to meet this demand.
- Competing priorities and demands – need to ensure workforce remains a priority for the system.
- Impact of the political landscape and immigration policy on workforce.
- Developing strong and stable leadership teams in the most challenged parts of the system.
- Time required to change training routes especially apprenticeships.
- Large scale OD programme to support the move to a new system model.
- Enhance the reputation of the NHS and social care making it the best place to work.

Dependencies
Workforce is an enabler that cuts across all of our workstreams, as demonstrated above. It is also dependent on other key programmes such as improvements to digital, our work on

estates and strengthening our links with social care. In order to meet our challenges it is essential that we continue to work closely with HEE, Higher Education Institutes and the NHS Leadership Academy as well as continuing to develop strong relationships with schools and further education institutes. We also need to work closely with the voluntary sector to develop and utilise volunteers.

Our task over the next five years and beyond
Ultimately we need to continue our focus on recruitment and retention and key to this will be preparing people and attracting them into entry level posts, developing them into roles and giving them long term career options.

Targeting local people who already live in north east London and working closely with schools and colleges gives us the best chance to retain trainees and staff in order to meet the increased activity caused by population growth and increased prevalence in long term conditions

Additionally offering clear career pathways, flexible working and improved health and wellbeing as well as developing clinical and managerial pathways and step down programmes at the end of people's careers, we will be able to offer an attractive career path for people, showing them that the NHS is the best place to work and retaining our staff for longer.

In support of the above and in line with the NHS Interim People Plan, we will:

1. Support our current staff and make the NHS the best place to work
    - An improved focus on staff wellbeing and providing the best environment for our people. Focusing on collective workforce wellbeing strategies; providing proactive support to minimise sickness and absence.
    - We will ensure awareness and training on the Workforce Race Equality Standard (WRES) across north east London and take positive action to support entry points and development of staff.
    - A commitment to tackle bullying and harassment by raising awareness of bullying and harassment policies and creating a workplace where staff feel safe and respected and able to challenge behaviour and express themselves freely while building a common set of values.
    - Improve BAME representation in organisations at all levels and work together to ensure a standardised approach across organisations to managing talent and providing clear support for progression.
    - Establish a NEL People Board by the autumn of 2019 to take forward our people agenda.

2. Improve the leadership culture

- Establish cultural values and behaviours we expect from our senior leaders.
- Implement leadership and management training and development opportunities to upskill staff.
- Contribute to the establishment of a London wide talent board and establish a regional talent board as part of the London wide architecture and governance review to support talent management.
- Work together to develop leadership competencies and programmes across sectors.
- Develop BAME leadership through our WRES work, scoping this at a London wide level implementing this at a regional level.
- Work with the London Leadership Academy to enable our leaders to deliver the best care possible to patients and service users.

3. Address shortages in nursing

- Continue to market NEL as an attractive place to live, train and work.
- Work with local universities and education partners to deliver high quality health and social care training to students across the partnership.
- Explore international recruitment as a medium term measure.
- Expand nursing capacity (complete from the e-workforce tool - 27 September)
- Building on our successful pilot programme, we will target 337 training nurse associates across NEL for 19/20

4. Deliver 21st century care

- Develop an holistic approach to workforce transformation and workforce growth by:
    - Outlining our plans for workforce growth – (complete from the e-workforce tool - 27 September)
    - Continue our work to develop apprentice roles across health and care, utilising the apprentice levy as a system and develop a new employment model for school leavers and learners.
    - Offer a structured approach to work experience with clear routes in to apprentice roles.
    - Ensure workforce is embedded in the overall efficiency and productivity plans for NEL.
- Enable mobility of our staff across the health and care system through improved technology making it easier to move staff across organisations within the partnership

5. Develop a new operating model for workforce

- Increase capacity by:
    - Developing collaborative staff banks to enable flexible and cross organisational working.
    - Exploring provider collaboration models for example the spin scheme in BHR, which sees GP federations working closely with providers.
    - Building on the requirement for training placements across the health and care sector ensuring there are job offers on completion of training.
    - Explore how best to utilise roles such as physician associates, nursing associates and social prescribers.
    - Work with training hubs to increase our placement capacity.
    - Make best use of workforce modelling and business intelligence.
- Increase volunteering opportunities across our health and care landscape and using this as a potential stepping stone to a future NHS and social care career. We have developed a project to scope and develop a model for volunteering in integrated care services in 2019/20 subject to NHS England funding.
- Explore apprentice opportunities as 2.3% of WTE health employees must be apprentices, presenting opportunities for people to build a career in health and social care.

The NHS as an anchor institution

An anchor institution is one that, alongside its main function, plays a significant and recognised role locally by making a strategic contribution to the local economy through employment, purchasing power and estates. The Health Foundation defines the NHS as an anchor institution because the size, scale and reach of the NHS means it influences the health and wellbeing of communities simply be being there. As local NHS organisations, we have a responsibility to ensure that our functions and resources have a positive impact on local communities.

Across NEL our NHS organisations employ large numbers of people, procure goods and own a large amount of estates and land, they are fundamentally tied to the wellbeing of the populations they serve and work in partnership with each other.

Barts Health NHS Trust is a good example of what this means. It employs a large workforce (24,290 staff, students and volunteers), has a longstanding history in east London (established in 2012 with the merger of three NHS trusts, St Bartholomew's Hospital has provided continuous patient care on the same site for longer than any other hospital in England. It was founded, with the Priory of St Bartholomew, in 1123), owns significant building and land assets (five hospitals and c1,500 beds), and has established partnerships with other public services. Additionally Barts is undertaking innovative work across employment, sustainability, partnership building as well as opportunities for further work in procurement and estates use as follows:

- Employment and careers – healthcare horizons which is focused on employing young people locally , Community Works for Health which supports general local employment and Project Search
- Sustainability - no waste to landfill, Whipps Cross on-site clinical waste treatment, anti-idling projects and cooking oil repurposed as fuel
- Estate redevelopment - Whipps Cross Hospital development and Whitechapel Life Sciences campus
- Procurement - work on increasing local SME spend and commissioning living wage employers
- Civic leadership/partnership - NHS/ELHCP, QMUL, UEL, local authorities/HWWBs and community/voluntary sector

City and Hackney local system has committed to a year-long action learning programme which will involve local health and care partners in collaborating to identify opportunities to deepen their role as anchors in the local community.

Each of our NHS organisations in NEL has a unique identity and we intend to maximise the social and economic value that the NHS as an anchor institution in NEL can bring to our local communities in the following ways:

- **Support our future workforce** - our workforce plans are underpinned by our aspiration to make north east London a great place to both train and work, and we are actively seeking out opportunities to develop career opportunities for our local population.
- **Develop our estate** - ensuring we make better use of our capital and estates to develop community assets, for example creating affordable housing and community spaces as part of capital development works.
- **Purchasing goods** – Where possible we pledge to look at how we can procure and commission more goods and services from local small and medium-sized enterprises (SMEs) including voluntary and community sector organisations. We will engage with

our vibrant and burgeoning voluntary sector to develop innovative approaches to service delivery as part of provider alliances.
- **Partnership working** - actively seeking out partnerships with other key "anchor institutions" across north east London, particularly developing further our partnerships with universities, schools and businesses that are particularly identified with north east London.
- **Sustainability** – through our sustainability work, adopt sustainable practices within the NHS and local community

As a partnership across north east London we will work together to utilise our assets and continually seek new ways to ensure we build on the social and economic value we can bring to the local population as anchor institutions.

The NHS in north east London as an anchor institution
- An anchor institution is one that, alongside its main function, plays a significant and recognised role locally by making a strategic contribution to the local economy through employment, purchasing power and estates.
- The NHS in NEL through employment, estates, purchasing and sustainability can make valuable contributions to local communities
- Across NEL we will work in partnership to maximise these contributions and enhance our workforce, estates and approach to sustainability.

Digital

Digital technology forms the bedrock of much of modern life. We shop online, book holidays, bank, browse a world of information and connect instantly with friends and family. In this respect our health care lags way behind. Due to chronic under investment or ineffective investment over decades, the NHS only effectively exploits digital technology in patches. This sets out the underpinning technological advancements that are taking place and are planned to enable the ubiquitous exploitation of digital technology.

Three key themes emerge from the digital policies, drivers and needs of the ELHCP, which form our informatics vision:
- a single systems approach - unification of clinical systems within organisations and across the partnership, as far as practicable
- connectedness - providing technology to clinicians and appropriate staff for seamless provision of excellent care, and connecting with other service providers to share data
- use of information - we will turn data into information and generate actionable insights for health professionals and patients to conduct research, treat disease and maintain and improve health outcomes.

Information Sharing Agreements (ISAs) form the bedrock of much of our digital work. We are well on its way to having only one ISA to support direct care which will simplify sharing arrangements for providers and the patients they serve. We are also using the Data Controller Console which is a Healthy London Partnership tool that moves the management of ISAs online which not only makes them easier to manage but also allows for greater transparency of our data flows. These steps allow comprehensive use of the east London Patient Record and Discovery, and for analysis of data for commissioning purposes. All organisational IG leads meet regularly to review the situation and make changes where necessary.

Shared records

The ability to view patient records for direct care purposes has long been a key ask of clinicians to enable them to provide care more efficiently, more effectively and more safely. The east London Patient Record (eLPR) has existed for around four years, originally in WEL and C&H. Around 120,000 shared records are viewed every month for direct care purposes.

Connected	Connecting 19/20	Connecting 20/21
Barts Health Homerton (acute and community) ELFT (mental health and community) NELFT (mental health and community) All GPs in C&H and WEL London Borough of Newham and Hackney (viewing only) St Joseph's Hospice (viewing only	By Q3: CoL Corporation, LB WF, Newham CHS and TH CHS By Q4: BHR GPs should be at least 95% complete LB Hackney (contributing records). BHRUT, LBTH, St Francis hospice (viewing only), 111 and OOH providers using Adastra	The LBs of Barking and Dagenham, Havering and Redbridge are expected to connect by the end of 20/21.

The eLPR will connect to the One London Health Information Exchange before the end of 19/20, initially via Homerton and Lewisham, in order to ensure that Londoners' health and care record is as complete and accessible as possible, regardless of where it needs to be viewed.

One London

OneLondon is an NHS England Local Health and Care Record Exemplar. The Local Health and Care Record Exemplars - or LHCRE - are a series of transformation programmes across England helping to improve how health and care services are delivered and experienced. In part, this is about making health and care information more consistent, more joined-up and more available to the clinicians, patients and families who need it.

Through the OneLondon programme, health and care systems across London are working together with Londoners to transform our health and care services by joining up information to support fast, effective and safe care. This involves London's five STPs working together to invest in the design, development and implementation of linked Local Health and Care Records for London, in collaboration with London's three Academic Health Science Networks (AHSNs) and the Greater London Authority (GLA).

Spotlight on: Supporting patient care through digital interoperability at the Homerton

Until 2013, Homerton Hospital was still grappling with the long-standing challenge prevalent in the NHS. How do we best support patients without immediate access to their medical history? How can we work differently so that valuable clinical and patient time is not spent on endless telephone calls and archaic paper-based systems chasing missing but important patient information?

The introduction of the east London Patient Record (eLPR) and Coordinate My Care (CMC) has helped answer much of this.

eLPR uses the Health Information Exchange system supplied by Cerner . It draws patient data from different organisational IT systems and presents this as a consolidated and longitudinal view of the patient record at the point of care, comprising information such as chronic problems, test results and medication.

CMC has been adopted by healthcare providers in City and Hackney (including the LAS) as an urgent care planning tool for frail/vulnerable adults and those under palliative care. Care professionals across the healthcare system all contribute to the patient's CMC plan. Through this shared care plan, CMC has been instrumental in building relationships between the care professional and the patient, and across care settings.

Using eLPR and CMC together now makes MDT meetings more clinically rich. Patients' medication and long term conditions can be identified on eLPR along with their personal wishes recorded on CMC to support decision making for the patient's on-going plan of care.

Population health advanced analytics

NEL, working in conjunction with the Endeavour Health charitable trust, has been developing 'Discovery east London' since 2016. Its aims are:

- To become an active contributor to the Learning Health System and a research-enabled community
- To predict, anticipate or inform individual health needs from algorithms running in real time
- Deliver insight across the whole care pathway, in primary or secondary care or elsewhere, to create opportunity for improvement and reduced adverse outcomes.
- To expand the existing population health programme in north east London, led by the Clinical Effectiveness Group at Queen Mary University London, to all health and care sectors.
- Enable real time reporting on programmes by providers and commissioners supporting clinical improvement and new payment mechanisms for value-based improvement. This reports on either pseudonymised or identifiable cuts of clinical data, as appropriate.
- Third party use by commissioners, public health, and academics to support research, development and planning, on consented identifiable data, or a pseudonymised dataset.

The Barts Life Sciences initiative and the Clinical Effectiveness Group are leading users of health data to create a Learning Health System in and beyond east London. Discovery will make the analysis of data and the dissemination of the learning derived from that analysis, much easier and more comprehensive.

The programme is a fundamental building block for a successful integrated care system (ICS). The Discovery Data Service (DDS) has been built to hold patient record information from every provider in ELHCP (including social care), combine it, normalise it and make it available (subject to robust governance mechanisms) to subscribers who have a particular and appropriate use for it.

Data fully imported and ready for use	**Data imported by end of 20/21**
99% of GPs (9 still to come online) Barts EMIS Community Barts & HUHFT ADT Key elements of Barts Millennium data Adastra data from three urgent care organisations.	TPP practices Barts – Procedures, Diagnoses, Clinical Events, Powerforms (Results and Prompts), Tests and orders BHRUT NELFT

	ELFT S1, MH Homerton acute and community all seven LAs, CoL Corporation

There will be significant demand for the information that the DDS can provide across NEL, and more widely across London as a whole.

Live	In testing
111 frailty flag API Extracts of data for TH Whole System Data Set STP BI team CEG database BHR Childhood Ims SMI reconciliation (ELFT) BHR Health checks BHR Diabetic recalls	Genes and Health Arterial Fibrillation Pancreatic tissue bank WF childhood immunisations and six week check

Discovery is being adopted as a core component of the One London LHCR programme and, as such, the development work in NEL will be boosted by £1m capital in 19/20 with a reasonable expectation that a similar amount will be made available in 20/21, although there will also be a reduction of funding from the Endeavour Foundation.

Patient enablement

Accelerate use of digital for patients in primary care
NEL is leading London with 57% of our patients able to interact with their GP via an electronic consultation system. Tower Hamlets has been selected as the 'Digital Accelerator' which is designed to work through the issues of how to transform the way patients interact with GPs. Innovative work also continues elsewhere, for example, 20 GP practices in Newham have launched video consultations to improve access for their patients.

Once established, these new pathways and ways of working will be rolled out across NEL, initially in 20/21. Video based consultations will be offered to all patients by practices from April 2021.

Spotlight on: online consultations

With Online Consult, clinicians at Stratford Village Surgery are now able to get through 30 patient queries in the same time that they would previously have taken for only 18 face-to-face consultations. Where consultations would usually take ten minutes, each form can be read and resolved on average in six minutes. Time-consuming tasks have therefore been replaced by ones which can be completed quickly so that staff can make better use of their time and respond quicker to more patient queries.

Clinical lead and GP Dr Barry Sullman said, "I can now easily see and treat patients who are house-bound or have trouble walking, as well as healthy people who find it logistically difficult to make it to the surgery, such as having to take a heavy pram down four flights of stairs. I have also been able to see agoraphobic patients, who would not have been able to travel to the surgery. Carers who are often rushing between clients also benefit from this technology as it enables them to 'meet' the doctor at a time and place which suits them. The technology has been working well and has enabled the quick eyeball assessment as well as a more detailed assessment of visible problems such as skin rashes".

Increase use of Coordinate My Care (CMC) by all providers
Currently local GP systems (apart from Microtest) have an in-context link in place to open up CMC from within a patient record in the GP primary clinical system. Clinical systems in hospital are developing a flag in Cerner Millennium to indicate if the patient has a CMC care plan in place, which will then allow access to the plan. This development will improve the visibility of end of life care plans across clinical settings, and support improved care for this cohort of patients.

Electronic Personal Health Records (PHRs) development and deployment
The ability of patients to take more control of their own wellbeing and healthcare needs is greatly enhanced when they have access to information about themselves and their medical conditions, and have the ability to interact with health and care professionals.

That's is why a fundamental component is that Personal Health Records **(**PHRs) are made available to patients. Working with the rest of London we are seeking to implement a single, comprehensive PHR that will show patients information from all the providers they interact with. The expectation is that this will be based on the Discovery platform within ELHCP.

The PHR will not only display information from all providers but will allow patients to record data they have gathered either manually or from their own smart devices. This might include mood assessments, levels of tiredness, or other self-assessed indicators.

In 2017/18, there were over 1.27 million follow-up appointments across the ELHCP. Assuming an average cost of £150 per appointment, just a small reduction in these appointment numbers would provide a significant financial saving to the system. This will support the national ambition to achieve a 30% reduction in Outpatient appointments.

A London-wide programme board has been created to determine how and if it would be possible to procure a generic PHR across London. The aim is to have such a system in place by the end of 20/21, although this is an ambitious target. We support this approach, recognising that significant implementation may take a number of years.

While the roll out of the NHSApp will continue and will soon provide access to eConsultations, it will not become the comprehensive PHR described above, but a gateway to it. Integration between any locally developed PHR and the national NHSApp and login will therefore be a key requirement. There are likely to be a number of 'niche' apps created for specific cohorts of patients. We are exploring options for children with asthma, Looked After Children and maternity. The national eRedbook system is currently being trialled by NELFT, as a potential electronic child health record.

Regular video based consultations in Outpatients
Barts Health has been trialling the use of video consultation software that helps patients and clinicians, where appropriate, to connect through virtual appointments by computer or mobile phone, rather than face-to-face. It aims to make it easier for patients to take control of their health while reducing NHS costs and the number of appointments that go unattended.

Two pilots are underway simultaneously at St Bart's – one with cancer patients, and the other with patients who have undergone treatment to control or correct abnormal heart rhythms. Around 12% of these appointments traditionally go unattended. However, all scheduled appointments using the app have been attended across both pilots (19 cardiology patients and 22 cancer patients).

Digital Continuing Healthcare Pioneer
We are currently in the process of applying to become a Digital Continuing Healthcare (CHC) Pioneer. Along with receiving support from NHS England, there is funding attached to support the development of digital solutions. If successful, we plan to use this funding to develop a CHC Information Technology and Data Management Strategy that will enable service transformation and future proof this essential service.

Infrastructure summary
The following changes are planned:

Health and Social Care Network (HSCN) - By December 2019 it is expected that the vast majority of General Practices will have migrated to the HSCN which will give most practices significant additional bandwidth, removing the main technical capacity barrier to use of video consultations and more effective participation in MDT meetings.

Digital First Accelerator - The main aspect of the digital accelerator is pathway redesign and subsequent transformation in terms of the way people work. This will clearly need to be underpinned by technology, such as HSCN, a fit for purpose Primary Care estate and relevant software in practices and Primary Care Networks (PCNs).

GPIT investment – The 19/20 GPIT budget for NEL is expected to be confirmed at around £2.1m and is expected to remain at a similar level going forward. This money is first and foremost to maintain the basic IT equipment in surgeries, and any money remaining beyond that base level will be used to mobilise the workforce and improve the ability to interact with colleagues in MDTs and with patients.

GP Connect – ELHCP is looking to exploit the nascent GP Connect capabilities which will allow individual data items to be pulled from and written to GP systems. For example, in 19/20 we will be able to query GP systems from Adastra systems used in urgent care settings to return free appointment slots and to then book a patient into that slot.

BHRUT
The Trust is now looking to make substantial investment in IT infrastructure and applications to improve the patient experience across various parts of the health and care system. Other system upgrades or replacement will see a new RIS implemented. This will allow a much richer availability of patient information for clinicians.

Barts Health
In the next three years Barts Health will have completed its VDI rollout, completed a full network replacement, implemented cloud based data centres and upgraded their Service Desk to include a self-serve portal for staff. In 2019/20 all hospitals will become paperless and record all clinical data electronically. Starting with the migration of nursing documentation to Millennium in autumn 2019, followed by electronic prescribing, medicines administration and physician documentation in the spring of 2020. This will allow detailed health records to be shared between medical practices and provide staff a more structured workflow. It will also introduce barcode matching for patient medication, paperless referrals, new patient tracking and alerts. All of this will quickly improve the quality of care provided to patients. A new Cerner HIE Data Warehouse will be procured jointly and shared with Homerton.

ELFT
ELFT is continuing to build on its RiO and EMIS systems. Key focus remains improving access to records and improving data quality. Both aspects are helped by the continuing rollout of mobile devices to clinicians and planned upgrades to the data warehouse, which will be augmented with wider data sets from Discovery. Implementation of the electronic Referral Service will also be an important project in the coming 18 months.

Homerton
eObservations modules in both Millennium and RiO will allow detailed clinical information to be more easily captured and made available across the hospital and wider care settings (via eLPR). Further expansion of the number of vital signs machines and the availability of WOWs will improve the quality of, and access to, information. Continuing work with London Borough of Hackney and City of London Corporation to bring them fully into the record sharing programme is expected to realise significant benefits. Asset management and GS1 compliance improves patient safety (reducing risk of litigation) and general efficiency in the running of the hospital. A new Cerner HIE Data Warehouse will be procured jointly and shared with Barts Health.

NELFT
NELFT is continuing to build on its RiO system. eObservations modules in RiO will allow detailed clinical information to be more easily captured and made available across NELFT and wider care settings (via eLPR). The system helps to proactively identify, escalate and alert medical staff to changing patient status. A key focus remains improving access to records and improving data quality. Both aspects are helped by the continuing rollout of mobile devices to clinicians and implementation of Offline RiO. Implementation of the electronic Referral Service will also be an important project in the coming 18 months. Implementing the Diagnostic Order comms module in RiO will improve clinical safety and reduce overall time from request to receipt by reducing use of paper for pathology and radiology tests. Community staff will be able to order results from acute trusts. Decision support systems will provide clinicians with alerts and information on patient conditions, and prompts for multi-set care plans and care pathway functionality. Remote assistive care tools will support MDT and virtual clinics allowing patients to book follow-up appointments online and link to patient portal. NELFT will provide integrated care through assistive technology, expanding use of wearable technology to support service users to use digital services to help manage their own condition at home.

Implementation plan

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Partners connect to the eLPR	Partners connect to the eLPR	100% compliance with mandated cyber security standards across all NHS organisations.
The eLPR will connect to the One London Health Information Exchange before the end of 19/20, initially via Homerton		
The Discovery Data Service (DDS) built to hold patient record information from every provider in ELHCP (including social care).	By Q4 data from remaining organisations made available: TPP practices Barts – procedures, diagnoses, clinical events,	

Data fully imported and available for use from all bar 9 GPs, Barts EMIS Community, Barts & HUH ADT, Key elements of Barts Millennium data and Adastra data from three urgent care organisations.	powerforms (results and prompts), tests and orders, BHRUT NELFT ELFT (S1 and MH), Homerton acute and community LA x7, CoL Corporation	
DDS development work in NEL boosted by £1m capital in 19/20 (similar amount will be made available in 20/21)		
	Digitally enabled new pathways and ways of working will be rolled out across NEL	
	Video based consultations offered to all patients in practices by April 2021	
The majority of General Practices migrated to the Health and Social Care Network (HSCN) removing main barrier to use of video consultations/more effective MDT meetings.		
Able to query GP systems from Adastra systems used in urgent care settings		
All Barts Health (BH) hospitals paperless and record all clinical data electronically	BH electronic prescribing, medicines administration and physician documentation	
One London undertaking further major public engagement on the eLPR		

As well as the use of data provided by Discovery for planning purposes that will underpin each workstream, the following table identifies specific areas where digital enables the other workstreams:

How digital enables workstreams

	Strategic digital priorities
Maternity	• Further development and integration of the antenatal self-referral forms • Development of an electronic PHR for use by women • Increased access to mobile devices for Midwives to use in the community • Widespread access to eLPR provides relevant information to all care settings • Use of Discovery to identify to primary care women with gestational diabetes recorded in the hospital EPR ensure that these women are

	tracked and provided with high quality pre-diabetes and diabetes care • Discovery will enable access for direct care by the GP or hospital clinical teams to information from both GP and hospital EHR relevant to a pregnancy prevention programme in women of reproductive capability taking valproate.
Urgent and Emergency Care	• LAS deployment of electronic patient record • Supporting Enhanced Health in care Homes with NHSmail and access to eLPR • CAS use of digital, specifically booking to practices • Use of CMC to improve % of people dying in their preferred place of death • Widespread access to eLPR provides relevant information to all care settings
Prevention	• Provision of information to commissioners and researchers from Discovery • Use of PHR and other Apps to provide information to patients and as a conduit to receive information from patients • Access to eLPR for community pharmacists • Use of frailty flagging to identify key people at higher risk • Widespread access to eLPR provides relevant information to all care settings • Use Discovery to match evidenced based interventions that can favourably alter patterns of behaviour or medical interventions, to patient risks and improve outcomes, either in terms of cost savings to the health care system and/or improved patient outcomes and satisfaction
Cancer and Rapid Access Diagnostic Centre	• Provision of eLPR and Barts Health systems to support Early Diagnostic Centre • Provision of information to commissioners and researchers from Discovery • Use of our data service would allow the tracking of the patient pathway through different health care providers in the year prior to cancer diagnosis, to gain insights that would facilitate earlier diagnosis. • The data service would allow tracking of those who were either referred under the 2 week wait route and those where a decision not to refer was made potentially to develop a health system wide real time cancer tracking tool.
Adults Mental Health	• Learning Disability and Autism flag in clinical systems • Implementation of messaging from NELFT to BHR GPs • Access to data to support the STOMP/STAMP programmes • Full digitisation of mental health providers by 2024 • Use of Discovery to reconcile SMI diagnosis across providers
Children and Young People and CYP mental health	• Provision of specific Apps such as for CYP with Asthma and for Looked After Children, subject from demand from service users • Learning disability and Autism flag in clinical systems • Implementation of messaging from NELFT to BHR GPs • Access to data to support the STOMP/STAMP programmes • Full digitisation of mental health providers by 2024 • Use of Discovery to reconcile SMI diagnosis across providers
Social Care	• Rollout of eLPR to remaining Social Care providers in NEL

	• Use of Discovery to support further integration of Health & Social Care data for planning purposes, supporting ICS development
Primary Care and Community	• Support for Primary Care Digital Accelerator to provide a 'digital front-door' to Primary Care • Provision of eLPR to BHR GPs • Provision of digital technology to support emerging PCNs • Delivery of GPFV Online Consultation targets
Planned care and OPD	• Development and integration of specialist apps such as MyIBD and MyBlood
Personalisation	• Use of PHR and other Apps to provide information to patients and as a conduit to receive information from patients • Use of real-time information to provide proactive care, as part of population health management
Clinical/Surgical Strategy, MSK, Pathology	• Implementing digital pathology system in Barts Health • Bleeding risk in hospital patients; the aim of this programme (informed by Discovery data) is to identify people on antithrombotic medicines at high risk of bleeding and to reduce bleeding by optimising medicines management – reducing interacting drugs and increased use of gastro-protective proton pump inhibitors (PPIs) • Discovery data will help with optimising shared decision-making for high-risk major surgery (OSIRIS)
LD and autism	• LD and autism flags will be added to EPR where they don't already exist • Commissioners are exploring ways of those with LD or autism being able to easily share their wishes and concerns with care providers
CVD	• Ensure the four major symptoms that determine planned cardiac referrals – syncope, breathlessness, chest pain and palpitations are recorded in clinical systems and exchanged both ways between primary and secondary care • Use of Discovery to facilitate integration of measurements from primary care, secondary care and the patients themselves, producing a more engaged, efficient and informed service.
Stroke	• Use of Discovery for Atrial Fibrillation to link the primary and secondary care pathway to enable individual linkage of process and outcome data. This will use routinely collected data to show how many people on anticoagulants have a stroke or bleed which will inform risk profiles and optimal drug prescription. For example, flagging those patients prescribed inappropriate medication, with poor anticoagulant control or at risk by virtue of poor renal function
Respiratory disease	• Discovery will be used to support CRUK Lung Cancer Study • Discovery data will help highlight practices with high prevalence of patients with asthma who present at A&E but could have been treated in primary care, with increased awareness or capacity in the system
Diabetes	• Discovery data will help highlight practices with high prevalence of patients with diabetes who present at A&E but could have been treated in Primary Care, with increased awareness or capacity in the system
Medicines optimisation	• Implementation of the remaining electronic prescribing and medicines administration systems in Barts Health, BHRUT and ELFT • Microbiology have detailed reports of local antibiotic sensitivity but with virtually no systematic use to support prescribing in primary care. For example: there is widespread use of antibiotics for

	example for urinary tract infection in adults that could be more effective were such data available. Decision support (Discovery) for AB prescribing in all primary and secondary care settings would enhance programmes to reduce inappropriate use
Ageing well	• There are two major causes of preventable adverse events which together account for 5-10% of emergency admissions in older people; o the use of the glucose lowering drugs sulfonylureas and insulin in older people with T2 diabetes which cause hypoglycaemia. o NSAID use in older people (much of which is prescribed at older ages though there is considerable self-medication) causes both CVD events and bleeds. Discovery will be used to identify people over 65 years with impaired renal function on SU/insulin and with low HbA1c values to review medication. Also, the patient who has had a previous peptic ulcer reported in the hospital record but not in the GP record will have a more complete record and NSAIDs are less likely to be prescribed.
Children's end of life care	• Widespread use of Co-ordinate My Care by all agencies and patients / carers wishing to use it, integrating over time with clinical systems and eLPR • Widespread access to eLPR provides relevant information to all care settings
Adults end of life care	• Widespread use of Co-ordinate My Care by all agencies and patients/carers wishing to use it, integrating over time with clinical systems and eLPR • Widespread access to eLPR provides relevant information to all care settings

Quality improvement

The terms 'Quality Improvement' and 'Improvement Science' describe a commitment to continuously improving the quality of health care, focusing on the preferences and needs of people who use services. They encompass a set of values (which include a commitment to self-reflection, shared learning, the use of theory, partnership working, leadership and understanding context) and a set of methods (which include measurement, understanding variation, cyclical change, benchmarking and a set of tools and techniques). For example the improvements made to 'joy in the workplace' as shown via the Tower Hamlets EQUIP (Enabling Quality Improvement Programme) project leading to increased service user satisfaction. QI differs from quality assurance because it is formative rather than summative in nature. It is a method of management which generates professionalism in a supportive no-blame environment, stimulating curiosity and learning. Its objective is to continuously improve health care processes in a way that will lead to improved outcomes.

The role of quality improvement in north east London
Organisations in north east London have been at forefront of engaging with and leading the development of QI approaches. This is a significant commitment but there is growing evidence that those organisations which invest in building the capacity and the capability of their workforce for systematic improvement achieve better results than those which fail to do so.

Example: Tower Hamlets CCG
Enabling Quality Improvement in Practice (EQUIP) is an innovative programme seeking to embed quality improvement methodology in primary care in Tower Hamlets. Using live operational data to promote a systems-based view of general practice, EQUIP aspires to move away from a place of low staff morale, increased workload and uncertainty, to a place where staff can experience joy at work and patients can enjoy a better experience of care. Initial evaluation of the programme in highlighted a high level of engagement with the programme, with 31 practices participating. 34 high quality projects were undertaken, with 26 improvement coaches recruited and trained and over 300 primary care staff trained in quality improvement. There was a positive shift in patient experience across EQUIP practices.

Developing a north east London approach to quality improvement
Organisations across north east London have adopted systematic improvement approaches and some work areas have developed NEL-wide quality improvement programmes. The primary care programme, as referenced earlier in this plan, has adopted an STP-wide primary care QI work stream. There are shared approaches to using a common QI project management system (Life QI) and a development matrix to support at-scale providers with improving QI capability and capacity across practices. Areas with well-developed QI programmes have been able to share learning and best practice across NEL.

Spotlight on: Simulation training to improve quality at patient safety at the Homerton

In situ simulation occurs in the workplace involving the interprofessional teams caring for patients in that area. Latent threats and system issues that potentially compromise patient safety can be identified through this learning method. Learning is promoted through team-based approaches as part of the normal working day.

The aims of the Homerton's in-situ programme are to make our services as safe as possible for patients and staff and create a positive learning environment, reflecting trust values.

Simulation-Based Education (SBE) National Standards guide the approach to designing, delivering and evaluating the in-situ programme. The challenge was to incorporate regular learning into everyone's working day and the sessions are

We undertake weekly, fortnightly and monthly sessions depending on the area and use portable simulation equipment to recreate clinical scenarios. The Homerton has been running this programme since 2014 which is now established in 23+ different wards/departments in secondary care and multiple GP practices and paediatric satellite areas in primary care. Not all scenarios are clinical – it also covers difficult communication, safeguarding, duty of candour, complex needs, and mental health.

There is a collaborative effort between the education team and clinical staff at all levels. It contributes towards newly-identified learning needs from any incidents that occur. This guides scenario design, delivery and debrief. Additionally, through the identification of latent errors we can proactively put measures in place to prevent things happening in 'real' time to 'real' patients. This trust-wide learning initiative has now become embedded into daily practice. The programme continues to improve with the introduction of latent error identification forms. The Homerton are pre-empting potential errors and through deliberate intervention can improve patient safety.

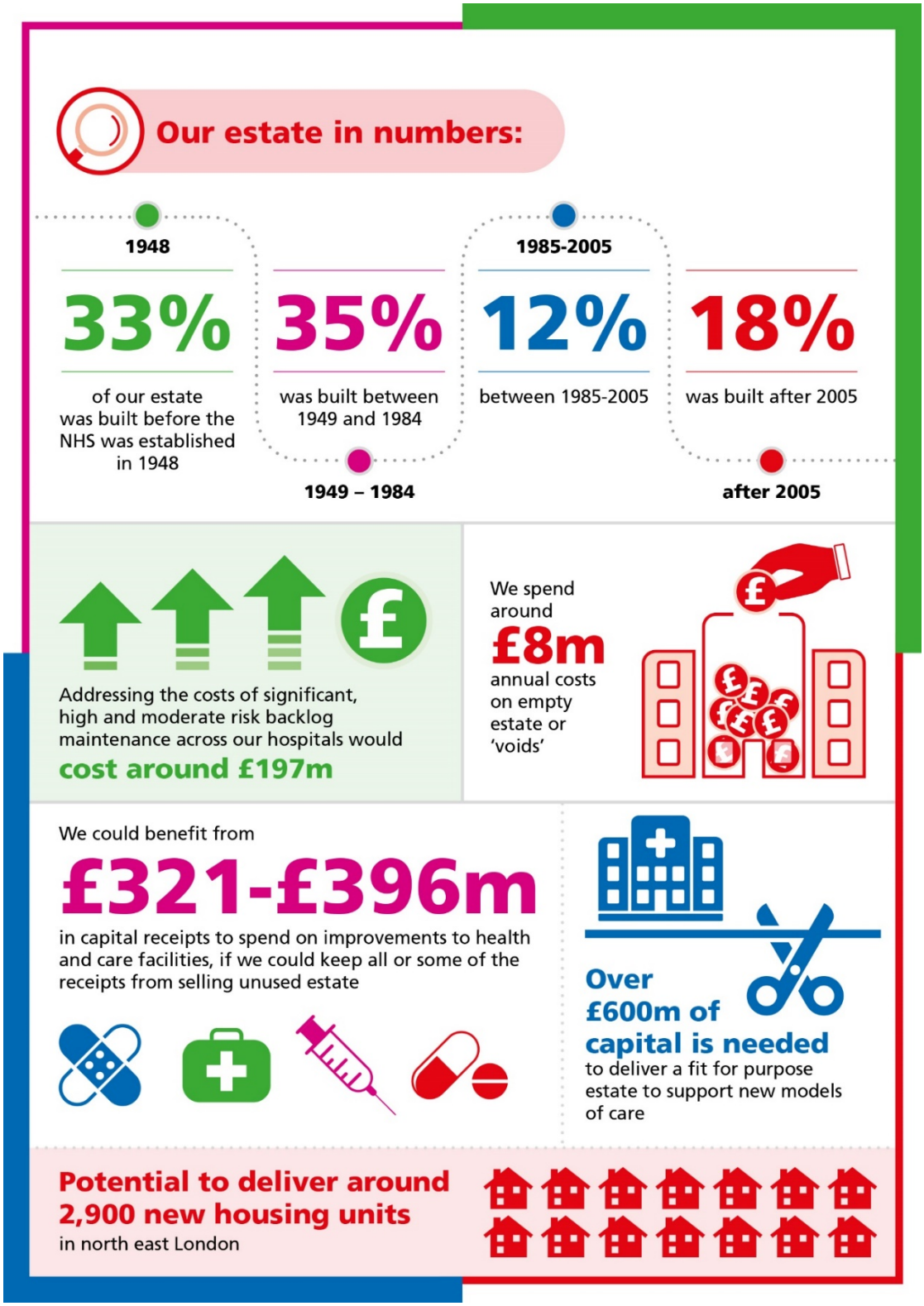
We have invested in nurturing a multidisciplinary faculty of various grades and specialities in order to deliver the programme. Learning is themed around technical skills acquisition

and recognition of the importance of non-technical skills to enhance patient safety. The simulation team has fostered a positive cultural change within the Trust.

Serial attendance at in-situ simulation appears to be correlated with improvement across a range of skills or knowledge that would be beneficial to exhibit in a medical emergency. This improvement is seen across specialty, discipline and seniority. This would appear to validate the resources expended on embedding an in situ simulation programme within a ward, department, hospital or community setting by improving staff confidence in communication, handover, location of vital clinical equipment and abilities in crisis resource management.

Estates

Infrastructure is a key enabler to facilitate the delivery of the LTP. The condition of the NHS estate in north east London is highly variable. It is of mixed-age, quality and fitness for purpose. We need to deliver care in modern, fit-for-purpose buildings and to meet the capacity challenges produced by a growing population and improve patient experience.

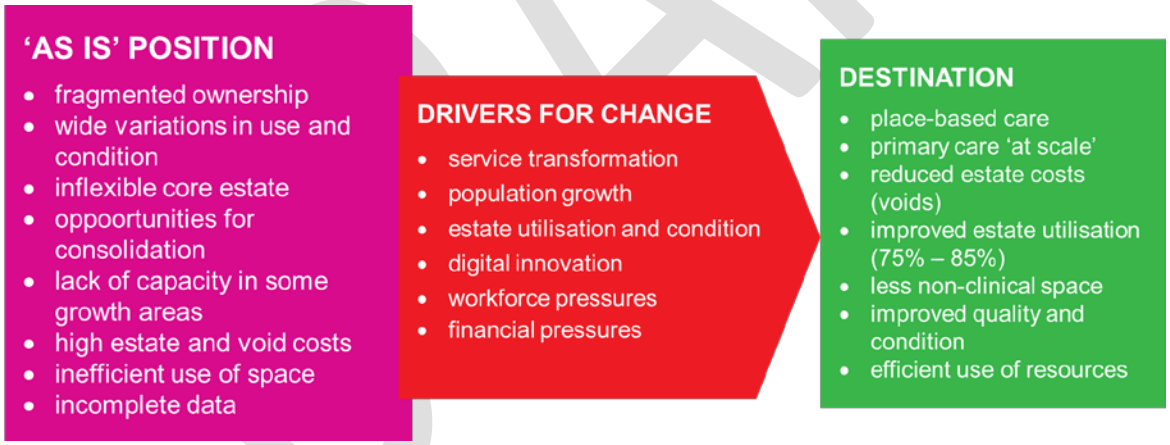


We have developed a consistent approach to assessing the impact of population growth arising from new housing developments. Working with the local authority planning departments, we can model the impact on demand for healthcare services at super output level and use this to support the application of S106 and CIL funding to develop new capacity.

We have agreed a single strategic estates plan for investment and disposals, utilisation and productivity. Estates are a crucial enabler for our system-wide delivery model. Our ambition is to develop good quality and cost-effective estates infrastructure which meets the complex needs of a growing, diverse and relatively transient population. Our estates will need to be flexible to support the delivery of new models of care over the next 5-20 years.

There are strong interdependencies between the new models of care planned for NEL and estates efficiencies. They cannot be delivered separately. The principles underpinning our estates strategy are:

- Better health and care outcomes assisted by health and social care services delivered in a fit-for-purpose estate
- Partnership between commissioners, providers and other public sector organisations to align incentives for estate release and support the delivery of new models of care
- Provide expertise and resources to develop infrastructure programmes
- Respond to clinical requirements and changes in demand to deliver a fit-for-purpose estate
- Increased operational efficiency of the estate, and maximum utilisation of the core estate
- Enhanced capability to deliver a portfolio of estates transformation projects.



There is also more work to be done to current, locally-based facilities to reflect our aspiration for new models of care in a way that maximises standardisation, flexibility, cost-efficiency and reuse of existing facilities. Our plan is based on working together to pursue opportunities for the current estates that include:

- increasing asset utilisation, revenue generation opportunities, void management, temporary uses and third party income generation
- reducing operating costs
- using technology, service transformation and workforce changes to increase efficiency
- using a One Public Estate approach to support shared services.

The highly variable quality of our out-of-hospital estate makes it challenging to improve facilities. A poor estate means poorer patient experiences, poorer working conditions for staff and lost opportunities to improve health and healthcare. To deliver our vision and address

the challenge of local population growth, it is clear that new, modern, state of the art facilities will be needed.

Our current portfolio ranges from recently built state of the art facilities at the Royal London Hospital, to facilities where significant investment is currently needed, such as at Whipps Cross Hospital.

The majority of the NHS estate in NEL consists of hospitals. Acute space and specialist hospitals make up 59% of the total. Current strategic commissioning intentions plan activity shift from acute to community and primary settings. Part of the primary care activity is a shift towards prevention and other providers such as pharmacists and community, but even with this reduction there will need to be significant investment in estate for primary care delivery.

Spotlight on: St George's Health and Wellbeing Centre, Hornchurch

Plans for a new health hub on the site of St George's Hospital in Hornchurch will help to transform services across Havering by modernising models of care and unlocking potential for improvements at other locations. The government has granted £17m funding to make this happen.

The hub will provide a base in the south of the borough for integrated local authority, community and mental health services and enable a wider range of services to be provided. It will be designed to support modern and emerging care models, with flexible clinical space, care navigators rather than traditional reception staff, hot desks in office areas and infrastructure for digital services. Community will be at its heart with a café in the foyer area and sensory gardens outside.

However it should be viewed at a local system level because it allows sufficient 'breathing space' for the much need reconfiguration of Queen's Hospital as well as providing a unified base for community services in the south Havering locality.

It will enable NELFT NHS Foundation Trust to consolidate staff from locations across Havering and provide a new and more appropriate home for a range of outpatient services currently provided at Queen's Hospital, Romford. Moving these services will in turn enable Queen's to better serve patients who need acute services, and expand its Intensive Therapy Unit and resuscitation areas.

Primary care services, many of which are in poor accommodation in converted houses, will be able to move in to the St George's site or areas of the South Hornchurch Health Centre vacated by NELFT.

The St George's development will fulfil the promise given to Havering people when the hospital closed in 2012 that another health facility would be provided on the site.

Improved utilisation
We can do much more to improve our use of existing community sector estate as providers move towards more agile working and make changes from fixed to sessional usage. We are working with NHSPS and Community Health Partnerships (CHP) on alternative leasing structures for better use. Our current estate utilisation is:

- acute 90%
- community 40%
- primary 90%

By improving utilisation on key 'strategic' sites, we can reconfigure and rationalise estate to make revenue savings. There is very limited opportunity to increase utilisation in the acute sector because the average utilisation is already very high.

There is a real opportunity at Queen's Hospital in Romford for investment to optimise utilisation and configuration of its services. The hospital should focus on high acuity work, with better joined up provision of out of hospital services. The site at Goodmayes offers a substantial redevelopment opportunity to invest in improved physical and mental health services, and workforce education and development. Technology and innovation also offer exciting opportunities to transform the way existing health and care estates support services in Barking and Dagenham.

Prioritising investment opportunities is key. We cannot deliver all projects simultaneously and our rational, systematic approach to prioritisation will help ensure requirements are met as early as practicable, and that resources are used effectively.

The capital pipeline for ELHCP transformational projects has been identified and prioritised. All projects (regardless of funding status) in the NEL plan were considered and assessed through criteria that included 'state of readiness' and 'transformational priorities'. Many projects are interdependent (such as the development of the St George's Health and Wellbeing Centre, which when open will free up space at other sites for NELT and BHRUT) and these interdependencies, along with state of readiness impacted on where they ranked in the prioritisation.

Our funding strategy maximises alternative funding sources, particularly where we can enter into partnerships with local stakeholders such as local authorities to reduce the net capital. Here are two examples:

- Tower Hamlets S106 £23m investment new health and social care hubs
- Newham AFO proposal £62m investment new health and social care hubs

Spotlight on: Redevelopment of Whipps Cross Hospital, Leytonstone

There is a strong consensus across all partners – including patients and public - about the need to redevelop Whipps Cross Hospital and the opportunity this provides to support delivery of the long term plan objectives, particularly around the provision of seamless integrated care for an ageing population. The case for change is well established. Over 43% of the hospital's estate pre-dates the NHS (more than double the national average). Many of the hospital buildings are not fit for purpose for 21st century care - having one of the largest backlog maintenance challenges in the country – and clinical adjacencies are poor, compromising the delivery of safe and efficient clinical services, which adversely impacts both patients and staff.

A new hospital would continue to provide a core set of emergency, secondary care and specialist services, but the proposed redevelopment of Whipps Cross is about far more than merely the rebuilding of a hospital. The size of the Whipps Cross site – 17.86 hectares – presents a unique opportunity to establish a wider health and wellbeing campus to support the delivery of integrated health and social care by a number of connected teams, along with supporting infrastructure. This would include housing, leisure and culture, to provide holistic care to the local population designed around their needs. As such, there is the opportunity to design new clinical pathways, a diverse range of support for patients, carers and families. This will be supported by innovative workforce models that draw on the strengths of the organisations within our system and the economic growth potential of the area to realise operational and economic efficiencies – the core of an integrated care system.

A refreshed Strategic Outline Case (SOC), is currently in development, with the involvement and support of partners across the ELHCP. This includes the development of a health and care services strategy for Whipps Cross which will be a key part of delivering the aspirations in the long term plan for our system. Common features of the emerging new models of care include: faster access to specialist treatment; rapid diagnostics and same day results; better care co-ordination; and closer working with primary and community services to deliver more care closer to home.

The vision is for Whipps Cross to become a centre of expertise for the multidisciplinary management of frail and older people, providing services focused on fragility, mobility, vision, hearing and balance for the whole population served by Barts Health.

The SOC is due to be finalised towards the end of 2019. Subject to approval by the Department of Health and Social Care and the Treasury, significant further work will then be undertaken to develop detailed plans at the Outline Business Case stage, during 2020 and beyond.

Implementation plan

By the end of 2019/20	By the end of 2020/21	By the end of 2021/22
Target to improve current utilisation average of around 60% for clinical space	Improve estates utilisation by 5%	75% utilisation of properties
Identify disposals opportunities	Disposal opportunities developed further following the outputs of the ELHCP capacity model	
Whipps Cross Hospital - refreshed Strategic Outline Case finalised	Significant further work to develop detailed plans at the WX Outline Business Case stage	Whipps Cross build starts – subject to funding
Structures and programme in place to deliver the St George's project	Confirm associated change at Queen's Hospital including transfer of outpatient services, expansion of A&E, ITU and resuscitation areas NELFT development of plans to consolidate staff from scattered locations	Disposal of Elm Park Clinic by NELFT potentially securing £950k for the local system.

Spotlight on: Newham Health and Care Space

The NHS in Newham has formed a £200 million partnership with Newham Council to develop and build new health and care centres across the borough. Health and Care Space Newham Ltd, which is owned by the council and East London NHS Foundation Trust, will build four new health and wellbeing hubs, eight GP practices and at least 180 affordable homes for keyworkers by 2035.

The company is the first of its kind in England and will use the Local Healthcare Alternative Finance Organisation model to access cheaper secure funding from the council through the Public Works Loan Board and commercial funders.
Money generated from rents and efficiency savings will be ploughed back into providing local healthcare and at the same time GPs – who will occupy 70 per cent of the new buildings – will benefit from lower rents.

The major capital investment will transform and renew the poor buildings housing health and care services in Newham and support integrated services delivered by new primary care networks.

It will improve services provided to people in the community through seven health and wellbeing hubs (four of which will be brand new), with minor surgery and treatment rooms on site in many locations.

At the end of the planned investment, HCSN will own 23 properties which will support the health needs of more than 80 per cent of the fast-growing population. More than 410,000 patients will benefit.

The company has already secured funding from the council for its first development, at Pontoon Dock Health Centre, and agreed to obtain 23 sites from the council, ELFT, GPs and other partners.

Research and innovation

We are committed to providing the best care for patients and recognise that by supporting research and innovation, we assist towards enabling breakthroughs, prevention of illness, earlier diagnosis, more effective treatments, better patient outcomes and sustainable improvements.

Our key strategic priorities on research and innovation include:

1. **Increasing the number of people participating in research**
   We will work to increase the number of people who are offered an opportunity to participate in health research. We will do this by working with our local academic partners, primary care networks and other health care providers to develop and agree a process which disseminates information on relevant research projects and facilitates recruitment of research participants across NEL. We will also explore the use of the NHS App for promoting research participation.

2. **Meeting excess treatment costs**
   We will continue working in collaboration with the Local Clinical Research Networks (LCRN) and NHS England to ensure that the treatment costs of patients involved in non-commercial research funded by the government and research charities, are met in a consistent, efficient and transparent way.

3. **Increasing the number of health and care professionals engaging in research**
   We will increase the opportunities for health and care professionals to engage in research-related activities and develop their skills on data coding and handling as well as interpretation of research findings. Apart from a positive impact on workforce recruitment and retention, such an approach can also assist to improve data quality, facilitate the translation of research evidence into practice and enable shared and informed decision making.

4. **Tailoring research to local priorities**
   We aim to develop a more proactive approach that ensures that local research addresses the needs of our population, promotes personalised care and reduces health inequalities. We will systematically reflect on our data and outcomes in order to identify unwarranted variation and we will engage with local stakeholders (including patients and their families/carers, front-line health and care professionals, the voluntary sector and academic partners) to develop our local research priorities.

5. **Contributing to creating a learning NHS environment that fosters evidence-based practice and innovation**
   We will promote evidence-based care and support the evaluation of local innovations. We will work with innovation partners (including the local AHSN and Care City) and will explore the opportunities that the regional test bed clusters may offer. We will facilitate the adoption of successful innovations and service improvements across north east London.

We are committed on building on our existing relationships with our local academic partners, the Quality Improvement expertise of several of our provider organisations and the significant progress in digital transformation in order to achieve a real expansion of research and innovation in NEL which will result in improved outcomes for patients, staff and the wider system.

Spotlight on: Barts Life Sciences

The need for pioneering, effective and affordable innovations in healthcare has never been greater. People in the UK, and the world, are living longer but not necessarily healthier lives. Barts Health NHS Trust and Queen Mary University of London, supported by Barts Charity have come together in a powerful partnership to help accelerate the latest healthcare innovations from bench to bedside. The partnership is called Barts Life Sciences.

Together, as Barts Life Sciences we have all the core components required to transform patient care for those living locally, nationally and internationally. As a partnership between a world-renowned research university and one of the largest hospital groups in the country, located in one of the best connected cities in the world we have something special to offer.

The vision is to create a life sciences hub in Whitechapel that will:

- Accelerate research and development through the innovation chain from the bench to the bedside
- Transform health and wellbeing, reducing inequalities and improving patient care
- Create a sustainable NHS that is recognised as a world-leader in prevention, prediction and precision healthcare

It will utilise data to drive innovation and deliver personalised treatments, position the UK at the forefront of life sciences innovation and create the infrastructure to promote growth.

There are three core priorities:

- **Prediction** – Artificial intelligence will play a vital role in allowing us to predict which medical conditions affect people, how the condition might evolve over time and what treatments might prove most effective. We have one of the largest patient populations in the country and access to extensive longitudinal data sets across east London. Used appropriately this data will be a rich resource for the

discovery and delivery of new technologies using predictive AI-enabled healthcare tools.

- **Prevention** – In order to tackle the significant challenge of avoidable long-term conditions, we must pioneer new ways that people can remain healthy. As an organisation with one of the most diverse local populations anywhere in Europe, we understand the prevalence of long-term conditions and the effect they have on patients, society and health systems. These insights should be harnessed for the discovery of innovations that maintain good health that can be delivered in the real world.
- **Precision** – Medicines of the future will be personalised to each of us. Using an individual's genetic code, we will be able to develop medicines that are tailored to each patient. This will ensure that we are delivering the best care to the patient, every time. We will avoid the need to expose patients to multiple treatments before finding one that works, delivering the best care for the patient and saving time and resource for health systems.

The plan to create the additional 1million sq ft of life sciences space will be delivered over five years from 2023 to 2028. The development will include commercial life sciences space, new teaching, research and academic facilities, clinical research facilities and a new, integrated health care centre for primary and urgent services. The hub will enable the development of strategic research and development partnerships, working with researchers and clinical staff on the delivery of end to end clinical trials within a globally representative population.

East London Genes and Health
The East London Genes and Health programme is a longitudinal study of people of Bangladeshi and Pakistani ethnicity within the east London community. This study is looking at the genetic makeup of volunteers to help researchers understand more about the nature of disease in the community. Findings will provide information on various health conditions that affect the population at large, and drive precision-based treatments for conditions such as heart disease and diabetes, transforming health outcomes locally and worldwide.

Clinical research
Currently there are over 32,000 patients from the local community actively involved in clinical research programmes, and in terms of scale, Barts Life Sciences is home to some of the largest clinical trials in the UK. The insights from these unique data sets can – and already are – being used to help drive the creation of new solutions which will aid the reduction of health inequalities locally, nationally and around the world.

Artificial intelligence (AI)
We will work with local providers to ensure the developments made by the national AI lab are adopted across NEL. The focus on diagnostics and treatments enabled by AI present an exciting opportunity for improving both the quality and efficiency of healthcare delivery, and we will work to utilise AI to augment clinical practice across the NEL system.

Spotlight on: Care City

Care City is an innovation centre for healthy ageing and regeneration, based in Barking and co-founded by the London Borough of Barking and Dagenham and NELFT. An independent community interest company, Care City enables research, innovation and education to create a happier, healthier older age for the people of north east London. The organisation works as the innovation partner to north east London's health and care system, enabling work of local benefit and national significance.

Among its many projects, Care City was part of the first wave of the test bed programme, run by NHS England and the Office for Life Sciences. Within the programme, Care City worked with:

- Barts Health, North-East London Local Pharmaceutical Committee, Waltham Forest CCG and Alivecor to develop a new screening and treatment pathway for atrial fibrillation
- Primary care in Barking and Dagenham and HealthUnlocked to build a social-prescribing plug-in for GP information systems

Both of these services are now going to scale across BHR, and being shared with partners nationally.

Building on these successes, Care City was the only test bed to transition to wave two of the programme. Its focus now is developing enhanced, digitally-supported roles for support staff:

- Domiciliary carers
- Healthcare assistants in primary care
- Administrators within acute settings

Digital innovation has huge potential to enhance the productivity, job satisfaction and progression of people across these roles, and to tackle north east London's challenges of workforce and integration. Care City's partnerships with the system means that this work is benefiting from the engagement and support of key leaders and clinicians across north east London, and has the potential to spread across the system.

Care City is a social enterprise, with twelve staff and ten projects - funded by Skills for Care, The Health Foundation, UCLPartners and the UFI Charitable Trust among others - attracting talent, ideas and resources to East London's health system. As NHS England looks to embed test beds in regional clusters, Care City providers a model of how entrepreneurial development can be combined with deep system partnership and real impact.

Genomics

In NEL we will draw on our existing strengths and partnerships in genomic medicine to support delivery of the Government's Life Sciences Strategy and increase access to personalised medicine for our diverse population, this also supports development of new care models and less bed-based care.

This includes:

- Active participation in the 100,000 Genomes Project as members of the North Thames Genomic Medicine Centre and Clinical Research Network (Professor Sir Mark Caulfield Chief Scientist and Interim CEO of Genomics England is also Director of the William Harvey Research Institute and Professor of Clinical Pharmacology at Queen Mary's University of London)
- Our NIHR Barts Health Biomedical Research Centre awarded in 2017 with a focus on translational genomics relating to inherited common and rare disorders, and the development of diagnostic and therapeutic cardiovascular devises and innovative trials (linked to Barts Heart Centre)
- East London Genes and Health led by Queen Mary's University of London and Barts Health which is one of the world's largest community-based genetics studies aiming

to improve the health among people of Pakistani and Bangladeshi heritage through analysing the genes of 100,000 local people
- Through our membership of the UCLPartners Academic \health Science Centre and Network.

We have also started discussions with the new London North Genomics Laboratory Hub based at Great Ormond Street Hospital including how we strengthen links between the GLH and the North Central and East London Cancer Alliance particularly as we realign our cancer partnership around our footprint and deliver our new cancer diagnostic centre; and secondly how we ensure equality of access to genomic testing across pathways and local populations within NEL.

Summary

- To deliver our plan we will need to ensure we have a robust workforce programme in place focused on supporting our current workforce to thrive, improving our leadership culture, addressing shortages in nursing, developing a workforce able to deliver 21st century care and developing a new operating model for workforce.
- Digital transformation will also be a key enabling function to deliver our ambitions. We will continue to build on the work we have done around shared records and accelerate the use of digital for patients in primary care.
- Infrastructure is a key enabler to facilitate the delivery of this plan and through our estates programme we will work together to deliver care in modern, fit for purpose buildings.
- As a partnership we will utilise research and development to support the delivery of the best care for patients. This will involve increasing the number of people participating in research, meeting excess treatment costs, increasing the number of health and care professionals engaging in research and creating a learning environment that fosters evidence based practice and innovation.

CHAPTER 7 - SUSTAINABILITY

Finance

Overarching vision for finance and contracting
The senior leaders in NEL have come together to agree a new approach to managing our finances, supporting the collaboration required to create integrated care systems and deliver the benefits outlined in the LTP. We have agreed an overarching vision, which is set out in the following challenges:

1. How can we best spend our health and care resource to improve population outcomes?
2. How do we best arrange financial flows through organisations to incentivise our workforce?
3. How do we reduce non value adding activity in finance to improve efficiency, enrich roles and attract and develop highly skilled finance teams of leaders?

We have agreed we need to develop a new financial framework and a set of strategic objectives to help us to collectively address these challenges and deliver the five tests for finance set out in the Long Term Plan. At a high level, these strategic objectives are as follows:

Strategic finance objectives

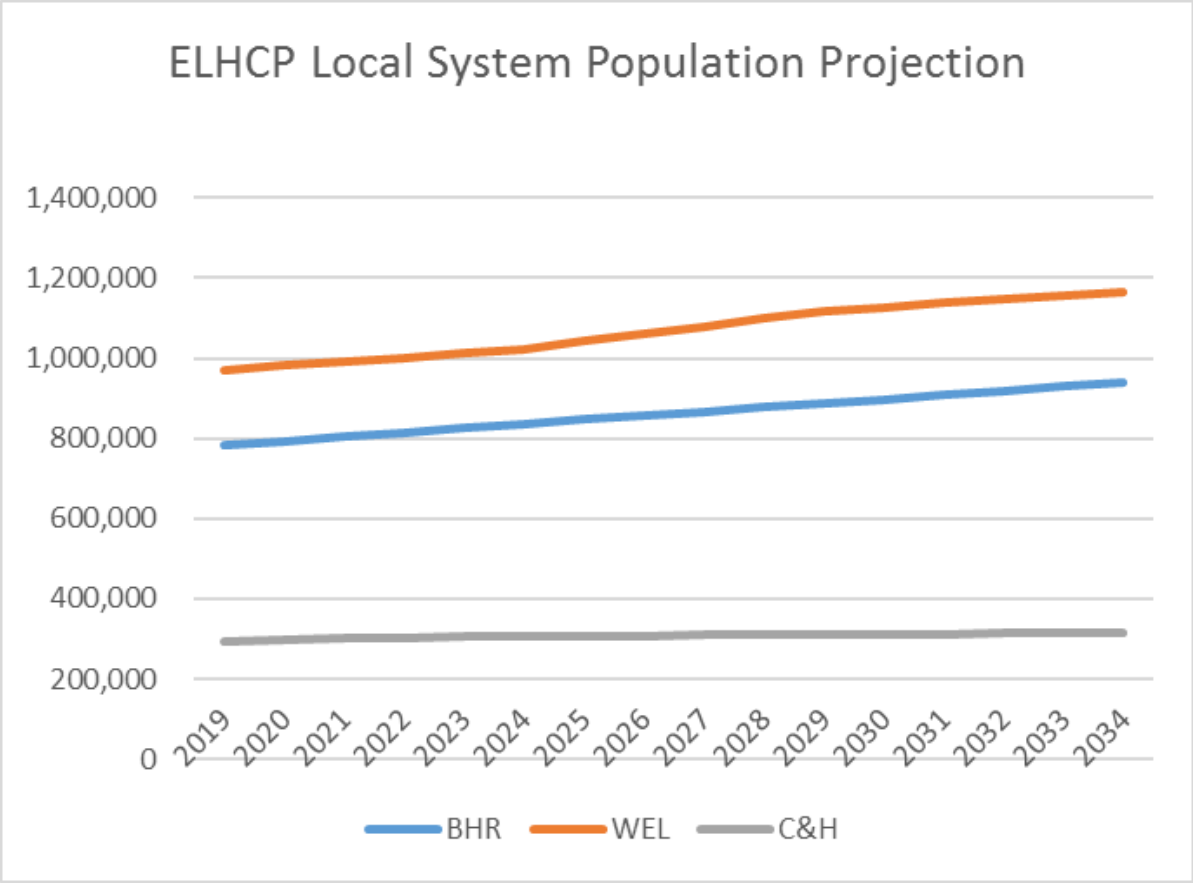
- ELHCP to become a thriving and financially sustainable system with all organisations in recurrent balance
- Better use of population health data to understand the underlying prevalence and health needs of our population, and a whole system approach to allocating resources based on need
- A new set of contracting arrangements that move us from a transactional approach based on activity volumes to an allocative approach that supports PHM
- Commitment to the mental health and primary care / community minimum investment standards, and development of a similar approach to protect investment in prevention.
- Support ELHCP transformation programme through managing the risk of stranded costs, recognising the double running cost of transition and positively incentivising change
- Support the development of a workforce to deliver the new models of care
- Provide an infrastructure to support more community-based care.

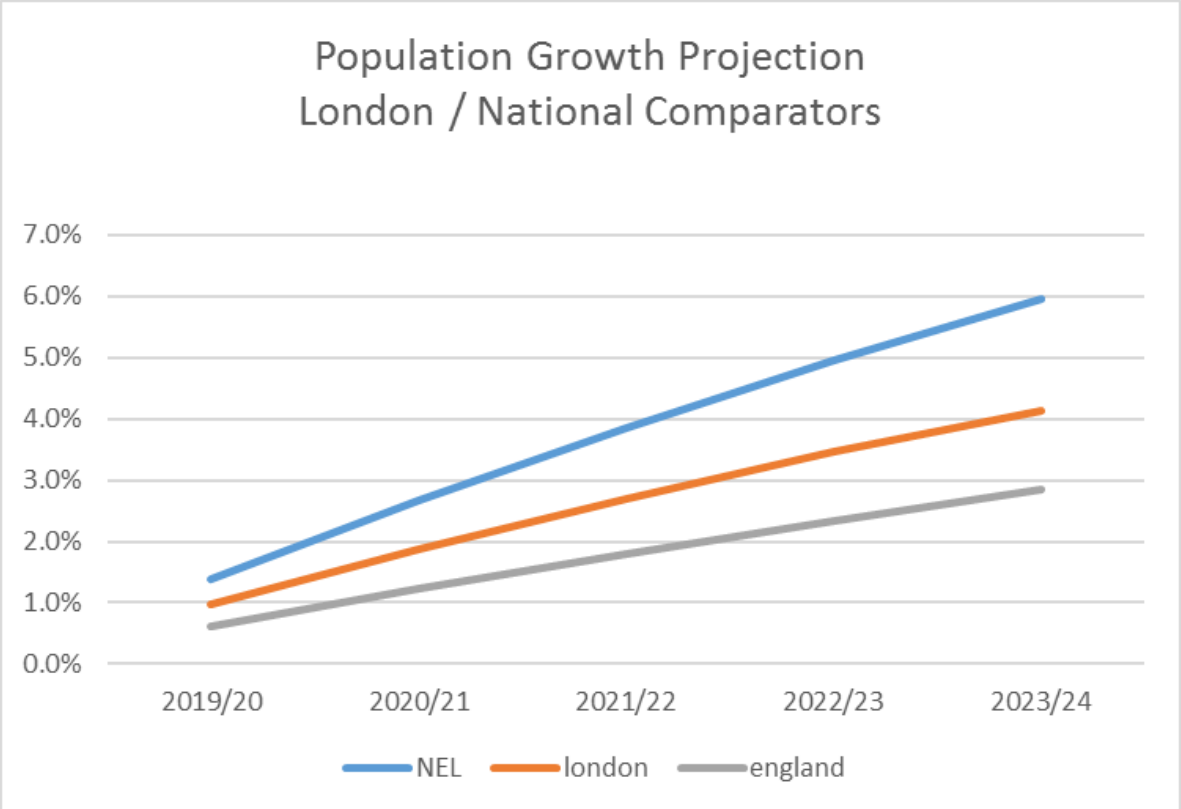
Delivery of the LTP challenges

Addressing unnecessary variation in services / care
Variations in the delivery of services across ELHCP cause material cost variations between commissioner boroughs as well as productivity gaps between ELHCP providers. To illustrate, over the period from 2013/14 to 2018/19 the BHR system had a growing excess of secondary care spend equating to >£100m/Year when compared to the average across North Central, North East and South East London(NCESEL) - 17 Boroughs and c.5m people with relatively similar demographic challenges. This excess spend has reduced to c.£90m in 19/20, the challenge remains to eliminate the full difference. Within providers, the medical productivity efficiency work streams seek to address this issue.

Population growth

North east London is anticipating a significant increase in population over the next 15 years, with the GLA predicting an increase in the order of 380,000 new residents. The increase is not expected to be uniform, centred on BHR and WEL (+20% increase in both systems) with lower growth in C&H (c.+8%).


ELHCP Local System Population Projection
1,400,000
1,200,000
1,000,000
800,000
600,000
400,000
200,000
0
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
BHR
WEL
C&H


Population Growth Projection
London / National Comparators
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
2019/20
2020/21
2021/22
2022/23
2023/24
NEL
london
england

On average, the anticipated increase, represents an additional 25,000 residents a year, for 15 years. By comparison, this is approximately 50% higher than the London average and twice as high as the UK average over the next five years.

The additional new population is expected to be younger than the average of the existing population, increasing demand for services required by young families (maternity, primary care related to paediatrics, A&E) on top of the existing older populations continuing care and long term condition needs.

Workforce
There are a number of workforce challenges, including;

- Agency utilisation which forecast at c.£100m 2019/20 (4.8% non-agency workforce expenditure) and is planned to fall over the life of the plan
- Ensuring that we have the skilled workforce to deliver the services needed by the local population. The plan seeks to address;
    - issues currently experienced in sourcing staff to deliver services such as IAPT in the BHR system
    - impacts of London weighting differentials across ELHCP
    - ensuring that services are delivered in such a way that increasing demand can be met

Impact of local authority funding reductions on healthcare
The ongoing pressure on local authority funding continues to put pressure on the social care funds, which impact on the health and wellbeing of various sections of our population.

The remaining part of the Finance Chapter is being reworked, following submission of the STP Finance, Activity and Workforce template. More work is now needed to triangulate the figures in the template with the aspirations in this plan.

Environmental and social sustainability

Sustainable development should not be seen as a nicety or an add-on. The NHS already disproportionately bears the impact for many societal health issues including air pollution, poverty and low social mobility.

We need to deliver services which are environmentally sustainable and which maximise the opportunities for wider social value and embed sustainable development principles at the heart of integrated care.

We want to ensure a sustainable health and care system that works within the available environmental and social resources protecting and improving health now, and for future generations.

This means:

- Taking urgent action to reduce carbon emissions and pollution,
- Tackling waste and inefficiency in the system and make the best use of scarce resources,
- Building resilience to the changing climate, both in practical adaptation and community cohesion and
- Nurturing community strengths and assets, capitalising on current work to develop anchor organisations and the potential to increase social value.

These are the cornerstones of our strategic approach going forward.

Building on the success in the City and Hackney local system, we will create two further local system level sustainable development plans – one for WEL and one for BHR. These plans set out how to improve prevention, target environmental hotspots (e.g. air pollution, energy and waste) address national priorities (e.g. carbon reduction) and capitalise on social value from commissioning and procurement activity. The plans will feed into and support individual organisational plans, build on and share current and best practice (local and national), comply with national requirements and legislation, and support innovation between the three local systems.

This means how we:

- Design and deliver healthcare without harm
- Mobilise immediate and effective climate action
- Make choices that enhance the wellbeing and life-opportunities for our residents
- Make choices that help us to live and thrive within our planetary boundaries
- Ensure that our progress does not leave anyone behind
- Collaborate and co-produce at every level.

Ensuring a successful sustainable development plan for NEL will not only reduce negative impacts – it will create maximum positive impact on the lives of patients and residents.

While the three strategies will support and build on local activity, overarching themes and outcomes will align at a north east London and national level.

We are leading action in four areas based on the Good Corporate Citizenship Assessment Model:

Accountability and ownership
To ensure we meet our sustainable ambitions we will be strategically placing accountability throughout NEL, at various levels of leadership and governing body positions. We are also taking a bottom-up approach to developing our plans to enable our significant workforce in NEL to take ownership of our sustainable development plans and embed them into 'the way we do things around here'.

Principles and values of sustainable healthcare
We are working across our health and care partnerships, and with local residents, to define the local social and environmental priorities. This will help our leaders to bring social and environmental value to the forefront of how we plan and deliver health and care services

Travel
The NHS is responsible for 5% of all journeys made in this country. As a group of organisations, we are committed to encourage active travel, e.g. walking to meetings, cycling, and car sharing and providers are exploring the potential for greater use of bicycles, electric/hybrid cars by staff and patient transport services. Examples of this include restricting new car loans for staff to hybrid or electric vehicles, positively promoting public transport and cycle loan schemes to staff, and we are working closely with Transport for London on specific plans for each of our main NHS locations to encourage patients and visitors to use more sustainable travel solutions.

Across NEL we are supporting staff to obtain maximum benefit from IT solutions e.g. providing portable devices and flexible working arrangements to minimise travel where appropriate. We are currently planning for the redevelopment of the Whipps Cross hospital site in Leytonstone, and are committed for the new facility to be environmentally sustainable.

Procurement

We are committed to improving and enhancing the embedded sustainable development and carbon efficiency principles within our procurement systems and processes. Bidders are required to demonstrate how they will meet these expectations around environmental impacts on the delivery of their services. Providers are required through the NHS contract to demonstrate progress on climate change adaptation, mitigation and sustainable development, including performance against carbon reduction management plans, and to provide a summary of that progress in their annual reports.

Significant opportunity to boost social and environmental value through our procurement processes have been identified in C&H and we expect to find the same across wider NEL. Capitalising on these opportunities, collaborating and sharing success will be paramount to our work over the next (length of plan) years.

Procurement leads from across the partnership are joining together to help standardise improvement across NEL and share best practice and learning.

Facilities management

Facilities management has a key role in making the NHS more sustainable. Sustainable facilities management ensures that environmental impacts are minimised and local economies and communities are supported in the operation of the NHS estate. This means:

- Complying with environmental and other appropriate legislation.
- Making highly efficient use of resources such as energy, water, land and products.
- Preventing and minimising waste.
- Protecting green space and biodiversity.
- Supporting local communities and economies.

At a staff level, all organisations in the partnership are committed to make the most efficient use of resources e.g. by:

- Recycling paper, cardboard, toner and printer cartridges
- Installing low energy light bulbs
- Limiting access to printers via staff ID badges and discouraging colour printing
- Increasing use of online solutions for routine business processes e.g. Workforce online system for staff management and payslips, software solutions for viewing meeting papers on devices.

Buildings

Decisions about the planning, design and construction of new buildings and the refurbishment of existing ones are important opportunities to contribute to health and wellbeing and to a more sustainable NHS.

In all building and refurbishment schemes we are working with contractors to ensure sustainable development objectives are properly specified, understood and delivered, and to meet the formal requirement to apply the BREEAM healthcare environmental and sustainability standard where appropriate.

We are using building projects to trigger improvement in other areas, like designing with wellbeing in mind, promoting active travel and cutting carbon, and expanding green and natural spaces. We are maximising sustainability performance through all phases of a building's lifetime – planning, design, construction and operation and intend to support a strong and sustainable local economy by involving local suppliers in building projects.

We are also exploring ways we can improve health and wellbeing in primary care networks through sustainable initiatives, for example, supporting food growing networks or enabling small scale community energy project centred around GP member practices,

Spotlight on: Barts Health's approach to sustainability

The Barts Health Environmental Sustainability Strategy 2013-2020 sets out its ambition for delivering world-class healthcare whilst ensuring that the organisation remains fit to do so both now and in the future. It has set a target to be the most sustainable trust in the UK by 2020.

Key objectives include:

- Reduce the trust carbon footprint by 34% by 2020 (based on a 2007 baseline)
- Reduce the trusts water consumption by 30% by 2020 (on a 2013 baseline)
- Reduce the trusts waste arising's, per patient, by 15%
- Fully integrate sustainable and ethical procurement practices into the Barts Health procurement strategy, policy and processes for all goods and services
- Embed sustainable behaviours through active change programmes

Outcomes

We will develop and advance the principles of commissioning environmentally sound and efficient services –from a local and global perspective -and the commitment to social value, across NEL:

- Co-create partnership level sustainable development plans for WEL and BHR that support and enhance organisational objectives and provide structured opportunities to pool resources.
- Highlight opportunities for improvement in current sustainable development plans
- Prioritise a healthcare without harm approach.
- Create engaged and accountable leads, and inspired delivery roles, across WEL and BHR organisations that are equipped to mobilise a fresh sustainable approach to health and care for 2020/21.
- Establish the NEL partnership is a beacon for sustainable best practice.

Summary

- We will work together as a partnership to meet the NHS five financial tests
- We are committed to becoming a sustainable financial system
- We will embed environmental and social sustainability across our footprint and deliver services which maximise the opportunities for wider social value

CHAPTER 8 – DELIVERY

Delivering our response to the Long Term Plan

This document has highlighted an ambitious programme of transformation, which aims to improve the health of our growing population across NEL. Our focus will be to ensure that our population are supported to live healthier lives and to receive high quality care when it is required. We will be using our resources to increase investment in primary and community care services whilst working in collaboration with our health, social care, voluntary and community sectors.

To support the delivery of this programme, we will establish an agreed approach and framework across the partnership, in line with the following principles:

- Focusing on supporting teams to deliver our proposed changes.
- Changing our models of commissioning to focus on delivering across pathways and boundaries.
- Focusing on an evidence based approach to service reform and change.
- Developing an information data set to understand performance against key metrics across NEL.
- Developing and implementing a common approach towards implementation, delivery and monitoring across transformation, performance and finance in NEL.

The Long Term Plan outlines a number of key metrics to measure performance against a range of priority areas including Mental Health, Maternity and Cancer. As part of our submission ("LTP Collection tool") we have supplied trajectories that detail our expected performance in these areas. These trajectories have been developed by our teams and represent both the ambition of our plan, but also take into account our current performance and local challenges which may impact on delivery. Our teams have been working closely with both local and regional organisations to ensure that our plans are realistic and achievable while suitably challenging to deliver both our ambitions and those of the wider NHS. Throughout the life time of the plan we will continue to monitor ourselves against these measures and use them as a key tool to ensure we are delivering.

Governance

The ELHCP will develop a robust governance model to support and deliver our STP plans. We will ensure that the STP provides strategic oversight across the partnership with the focus on local accountability in our systems and programmes. The STP executive, which was established in 2016, will continue to provide operational direction and assurance to the ELHCP. The executive comprises of our member organisations who will be responsible in promoting the work of the STP.

Building on our public engagement

We are committed to engaging with our local community across NEL in the development and delivery of our plans. We will continue to work closely with our partners across the system, all of whom have embedded engagement structures and regularly engage with local people and service users. The plans outlined in this document incorporate feedback gathered through engagement activity carried out by our partners, as well as through ELHCP's citizen's panel surveys, stakeholder meetings and partner events and forums .In April and May, our local Healthwatch organisations conducted a survey for local residents and carried out a series of focus groups with local communities. These focused on our priorities for personalisation, prevention and primary care.

Continuing our engagement prior to the submission of our final plan, we will be focusing on the following engagement priorities:

- Conducting a survey using the ELHCP's citizen's panel, reaching over 1000 people to gain feedback on our draft LTP response.
- Attend a range of scheduled community events and forums, to include:
  - Patient Engagement Forums
  - PPG network meetings
  - Community and voluntary sector meetings
  - Stalls at local events

An engagement priority for the ELHCP is to improve our information, which is accessible for those whom English is not their first language or who do not speak English. We will be committed to improving our communication, particularly for those who have a long-term condition. We will therefore be carrying out some targeted engagement with people in our communities with lived experience of long-term conditions and for whom language may be a barrier. This will include two focus groups with people with respiratory disease, as identified by Healthwatch.

The feedback we receive through the engagement activity we carry out during October will enable us to better prioritise and address gaps where we have them. We commit to publishing a 'you said we did' outlining how the feedback will be used.

This engagement activity on our response to the long-term plan is not standalone – it is an important part of our journey to becoming an Integrated Care System. Developing and embedding a shared approach across the system to timely and meaningful engagement is a priority for ELHCP. We have already started mapping out where there are opportunities to involve local people in the development of our plans over the next six months to a year and in November, we will be running a workshop with our engagement colleagues to discuss this further. This will be form the basis for a detailed communications and engagement plan. In addition, later this year we will be developing a co-production charter which itself will be co-produced with our partners.

Spotlight on: Co-production

"Co-production" is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.

It is now widely accepted that the best way to improve health and care services is to put the patient at the centre of everything we do. To move beyond rhetoric this must entail more than existing public engagement, involvement, participation or consultations. There needs to be a commitment to working with patients and service users to design and commission services that meet their needs and then involve them in monitoring how the services are delivered. This can be termed co-production as in the Care Act 2014.

There are a number of examples of co-production across north east London for example in ELFT, their 5th quality conference was co-produced with service users and carers.

This approach was also adopted to prepare the long term delivery plan for mental health in north east London started with a mental health summit. People who had come into contact with mental health services told their stories to an audience of over 100 people who work in mental health services. These stories were then used to identify priorities for action to improve their experiences. The summit was followed by a workshop of staff and

service users where action plans were designed that set out how we can deliver the identified priorities.

Residents in Hackney are helping to shape local health and care services through co-production. Healthwatch Hackney and Healthwatch City of London developed a co-production charter in 2017. It is now endorsed by the main local health and care organisations including City and Hackney NHS clinical commissioning group, Hackney Council, City of London Corporation, Homerton hospital, East London Foundation Trust and Hackney CVS.

More than 40 people currently work with Hackney Council's Adult Services department to co-produce services in different ways. Some examples include people sitting on staff recruitment panels for Hackney's Adult Services, delivering user-led training, evaluating and feeding back on services and co-chairing Council board meetings.

The charter – the first of its kind in England – sets out the principles for how to co-produce health and care locally including involving people from the start in service redesign and valuing them as equal assets.

We have now extended this approach and have the support of all of the Healthwatches in north east London to apply the principles of co-production. We will now apply the principles of co-production as part of our north east London long term delivery plan and will produce a charter for co-production.

The charter will set out how co-designing services (staff and the public working together to design or improve new services) is important but that the process of co-production should also be accompanied by co-delivery (involving people in actual service provision) and co-monitoring (making sure that the new service is delivering the right care to the right people).

The charter will recognise that people will wish to be involved in different ways. One person may wish to attend just one meeting to discuss how blood tests are commissioned while another may wish to help design, deliver and monitor a better way of caring with people living with dementia - all contributions will be valued. The charter will establish some shared principles such as people being paid fairly to take part in any work and valuing them for their skills, knowledge and experience. It will be an essential tool to help put the patient at In the heart of everything we do.

The first step is to co-produce the charter for co-production. The charter will be designed, delivered and monitored with people from across north east London but it will not be used to impose uniformity. It will set out the key principles that will be applied in different settings and in different ways. It will reflect the diversity of our communities and the challenges they face in becoming healthier and happier as we deliver the ambitions set out in the NHS Long Term Plan.

Conclusion

This first draft Plan is the result of considerable work across the health and care system to review our existing strategy in the context of the national Long Term Plan, the London Vision, and the changed circumstances we find ourselves in as a system since 2016. There are many firm recommendations and commitments in the Plan, which reflect the iterative and developing nature of the partnership and where most progress has been made to date.

This Plan continues in its development, and a finalised draft will be produced in November 2019. This draft will develop further those areas we have highlighted where further work is underway, and will benefit from the results of the Health Education England workforce tool data that will be made available to us in October. Additionally further discussions continue between all system partners on finance and activity levels, as well as on the Long Term Plan metrics by which we will be assessed.

During October we will involve local people and their representatives more in the development of more detailed plans, particularly through local places and systems. We intend to produce a summary version of the Plan in November in plain English. We will also use October to engage further with all our staff and volunteers across the health and care system who have a key role to play in the delivery of the Plan.

Finally, we will be finalising an Accountability Framework for our emerging Integrated Care System which will ensure clarity on the role and expectations of Primary Care Networks, place-based partnerships, local systems and partner organisations in delivery. By April 2020 we will have in place a coherent Implementation Plan with improved governance making clear where responsibility for the delivery of key outcomes sits, and the delegated resources that will be agreed to flow from the ICS to each level of our system.

September 2019

Title of report:	*City and Hackney Prevention Investment Standard: discussion paper*
Date of meeting:	10th October 2019
Lead Officer:	Jayne Taylor, Faizal Mangera, Anna Garner
Author:	Jayne Taylor, Faizal Mangera, Anna Garner
Committee(s):	*Accountable Officers Group – 17th September 2019*
Public / Non-public	Public

Executive Summary:

This paper considers potential mechanisms for increasing the focus on and resource allocated to prevention in City and Hackney system commissioners and providers. We propose to create a 'prevention investment standard' – our commitment to grow investment in prevention activities. We also propose to pilot two funding vehicles aimed at incentivising prevention activities in the community and in statutory providers.

Recommendations:

The **City and Hackney Integrated Commissioning Boards** are asked:

- To **NOTE** the report and provide feedback;
- To **CONSIDER** the funding vehicles set out in the report

Strategic Objectives this paper supports:

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

Specific implications for City

Prevention Investment Standard would be across whole City and Hackney system

Specific implications for Hackney

Prevention Investment Standard would be across whole City and Hackney system

Patient and Public Involvement and Impact:

No PPI yet: aim to take proposals to Transformation Board on 23rd October for wider engagement. Impact on perceptions of service providers should be positive (allow for more patient-centred care and preventing ill health and associated challenges in thepopulation) but more consideration can be given when proposal has more detail developed

Clinical/practitioner input and engagement:

None yet: aim to take proposals to Transformation Board on 23rd October for wider engagement

Equalities implications and impact on priority groups:

TBC when more detail on priorities for service providers and criteria for community fund decided

Safeguarding implications:

None

Impact on / Overlap with Existing Services:

Proposals about additional services and ways of working. More consideration can be given when proposal has more detail developed.

City and Hackney Prevention Investment Standard: discussion paper

Feedback requested from ICB on:

1. Principle of the Prevention Investment Standard
2. Initial proposals for potential funding mechanisms to implement the PINS
3. Proposed next steps
4. How do we manage a commitment to increase resourcing for prevention at the same time as managing budget pressures across partners?

Strategic context

System aims and objectives

Investing in prevention is a system priority for City and Hackney (as exemplified by the Integrated Commissioning Board strategic objectives and supported by the NHS Long Term Plan; also in line with the government's Prevention Green Paper and a Faculty of Public Health discussion paper), with two aims:

- improve the long term health and wellbeing of local people and address health inequalities; and
- achieve financial sustainability for the City and Hackney system.

The purpose of the proposals set out in this document is to support these aims by creating a mechanism for how the City and Hackney system can:

- understand its level of investment in prevention activities;
- ensure the level of investment is, as a minimum, protected;
- ideally increase the allocation of funding towards prevention activity (as per ICB objectives) while delivering current priorities and required outcomes;
- monitor and deliver a financial return on investment in prevention, improving system financial sustainability.

The proposals are also intended to influence system behaviours and support a culture shift as part of wider prevention strategies, by impacting on:

- the capacity and capability of system partners to deliver prevention activities;
- ways of working of local organisations (attitudes, perceived responsibility for population health, policies and processes) to prioritise prevention and promote understanding of the role all local partners can play in delivering prevention initiatives.

Defining prevention

The National Audit Office suggests that, broadly, early action constitutes three types of work: (primary) prevention, early intervention (secondary prevention) and early remedial treatment (tertiary prevention).

- **Primary Prevention:** preventing, or minimising the risk of, problems arising – usually through universal policies like health promotion or a vaccination programme
- **Secondary Prevention:** targeting individuals or groups at high risk or showing early signs of a particular problem to try to stop it occurring, for example screening programmes.

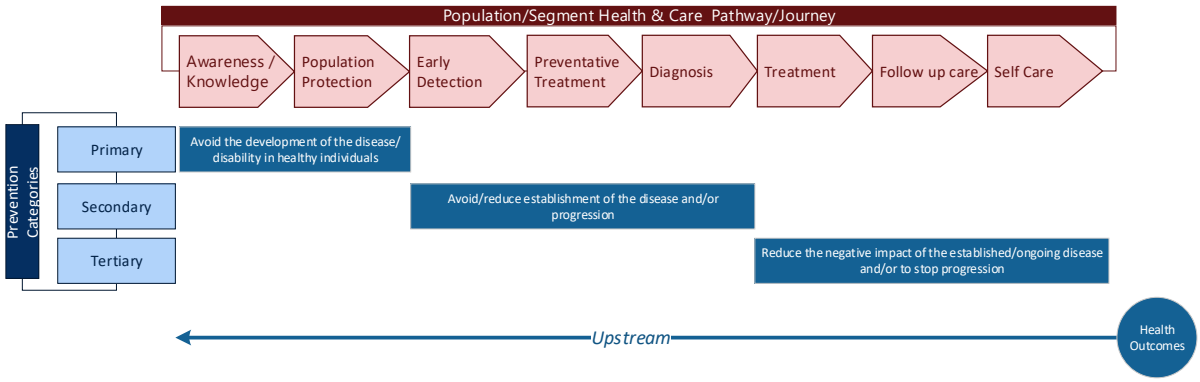
- **Tertiary Prevention:** intervening once there is a problem, to stop progression or deterioration. For example, work to prevent reoffending and reablement programmes.

Conversely, reactive interventions are those which act to manage the impact of a strongly negative situation, but do little to prevent negative consequences or future reoccurrence, for example aspects of acute hospital care.

We want to shift the balance between prevention and reactive spending and move our interventions 'upstream'. By intervening earlier, we will improve the health of City and Hackney residents while also avoiding expensive reactive interventions.

Source – [Health and Wealth Closing the Gap in the North East](#) (2018)

If we adopt these definitions of prevention it is apparent that a substantial proportion of current local system activity already meets this definition. The below diagram illustrates how we might allocate types of activity between prevention tiers:



Methods of ensuring increased investment – initial proposals

We have suggested an overarching mechanism for ensuring increased resourcing of prevention initiatives could be a Prevention Investment Standard:

Prevention Investment Standard (PINS) – this is our **commitment** to grow investment in prevention activities year on year at a faster rate than growth in general health and care budgets. Over time, this standard would support a shift in investment and focus towards prevention activities, supporting the idea of health as an asset to be protected (rather than a problem to be treated). This requirement lends itself to an approach based on 'parity of esteem', similar to that applied for the mental health investment standard.

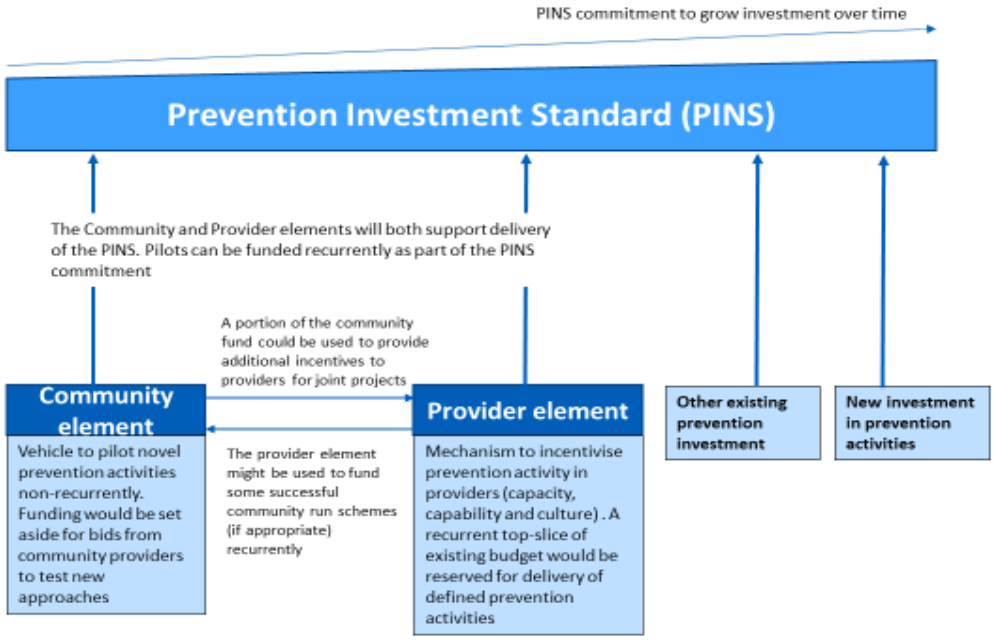
NB: Local authority budgets for public health and other areas of prevention have historically not grown at the same rate as health budgets and have in recent years been subject to cuts. This constraint on funding is likely to continue over the next few years and growing prevention spend across the system will require collaborative working.

Potential funding mechanisms

To support the delivery of the PINS, two potential vehicles to fund prevention activities are proposed below.

Community Element – the primary purpose of the community element would be to fund community and voluntary sector organisations to drive innovative prevention activity at a community level. This funding vehicle could initially be financed through CCG non-recurrent funds (from underspends during the year) but could move in time to being funded via savings delivered in previous years by successful community schemes.

Provider element – a proposed incentive scheme to increase focus on preventative activities within statutory provider contracts, where a proportion of the contract value is paid on the basis of delivering defined prevention initiatives/activities. This could be a mechanism for delivering a sustained growth in prevention spend as well as engaging statutory providers in an ongoing focus on prevention.



Example: *£2M of non-recurrent CCG funding could be allocated in 2019/20.*

1. *£XM to pump prime a provider element for initial year to support organisations while moving to new care models; going forward this will be a top slice of budgets and paid if specified conditions are met/activities delivered.*
2. *£XM available for the community element for prevention projects (e.g. £100K per Neighbourhood/Primary Care Network area, for one or multiple projects per Neighbourhood): lead organisation must be community or voluntary sector provider but the related service can be delivered in partnership with other organisations including statutory providers.*

Next steps

1. Engage workstreams on plans for PINS including priorities for both community and provider elements
2. Draft mobilisation plan for the community element, in discussion with the Neighbourhoods team to establish robust and fair method of allocating community funds. Proposal to be brought back to ICB in November.
3. Draft mobilisation plan for the provider element (to be brought to ICB in January 2020), using the Transformation Board (October) to develop proposals, in particular to:
    a. identify how local health and care providers and commissioners can support an increased focus on prevention
    b. define what enablers organisations would need for this to happen
    c. outline immediate priorities for inclusion in the provider element
4. Work up more detailed proposals for how we establish baseline for and monitor increased focus and resourcing of prevention activities. Proposal to be brought back to ICB in November.

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the members of the Finance Economy Group.
If there are any legal implications which require consultation with legal counsel, please make reference to that below.
Please ensure you have appropriate sign off for your report, along with the papers. Papers which have not been signed-off by the appropriate officers will not be considered]

Workstream SRO: Anne Canning, Prevention SRO

London Borough of Hackney: Anne Canning

City of London Corporation:

City & Hackney CCG: David Maher, MD

<table>
<tr><td>Title of report:</td><td>Mental Health Strategy</td></tr>
<tr><td>Date of meeting:</td><td>10 October 2019</td></tr>
<tr><td>Lead Officer:</td><td>Dan Burningham – Mental Health Programme Director, City & Hackney CCG</td></tr>
<tr><td>Author:</td><td>Mental Health Coordinating Committee Members

(City and Hackney CCG, Hackney Council, City of London Corporation, VSO rep, Healthwatch Hackney, Mental Health Service User Committee, ELFT)</td></tr>
<tr><td>Committee(s):</td><td>
<table>
<tr><th>Committees /Meetings</th><th>Dates</th><th>Purpose</th></tr>
<tr><td>Prevention workstream meeting</td><td>12 February 2019</td><td>Review and comment</td></tr>
<tr><td>Planned Care workstream meeting</td><td>19 February 2019</td><td>Review and comment</td></tr>
<tr><td>Unplanned Care Meeting</td><td>29 March 2019</td><td>Review and comment</td></tr>
<tr><td>Prevention workstream meeting</td><td>9 April 2019</td><td>Review and comment</td></tr>
<tr><td>Planned Care workstream meeting</td><td>16 April 2019</td><td>Review and comment</td></tr>
<tr><td>City of London Health and Wellbeing Board</td><td>14 June 2019</td><td>For information</td></tr>
<tr><td>CYPMF Strategic Oversight Group</td><td>17 June 2019</td><td>Review and comment</td></tr>
<tr><td>City of London Summit Group</td><td>25 June 2019</td><td>For decision</td></tr>
<tr><td>City of London Community and Children’s Services Grand Committee</td><td>12 July 2019</td><td>Review and Comment Delegate approval of the final version to the Integrated Commissioning Sub-Committee.</td></tr>
<tr><td>Mental Health Coordinating Committee</td><td>15 July 2019</td><td>For approval</td></tr>
<tr><td>All Workstreams</td><td>19th July 2019</td><td>For information</td></tr>
<tr><td>Integrated Commissioning Board</td><td>10 October 2019</td><td>For approval</td></tr>
<tr><td>Governing Body (Public)</td><td>TBC</td><td>TBC</td></tr>
<tr><td>Hackney Health and Wellbeing Board</td><td>TBC</td><td>TBC</td></tr>
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</td></tr>
<tr><td>Public / Non-public</td><td>Public</td></tr>
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Executive Summary:

This report presents the *City and Hackney Mental Health Strategy 2019-23* has been developed as part of work being led by the Integrated Commissioning Board to develop integrated approaches to health and social care, including mental health. It sets out our priorities for mental health support and services across City and Hackney for 2019-2023. It assesses the needs of our population, maps the challenges, identifies the opportunities, and explains how we will work collaboratively as partners - and with service users - to deliver our priorities, and how we will monitor our progress.

Development has been overseen by a Mental Health Co-ordinating Committee (MHCC) bringing together partners, and supported by a joint editorial group, with service user representation.

The strategy has been reviewed by committees across the integrated care system. The four integrated commissioning workstreams have been asked for their input, and these discussions have fed into the final draft for submission to the Integrated Commissioning Board.

The strategy has been approved by City and Hackney CCG and the City of London Corporation. In view of the integrated nature of this strategy the City of London Corporation have proposed that approval of the final document is delegated to the Integrated Commissioning Sub-Committee, which provides the membership of the Integrated Commissioning Board. Approval from the London Borough of Hackney is pending.

Recommendations:

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

- To **APPROVE** the Mental Health Strategy

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

- To **APPROVE** the Mental Health Strategy

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	☒	We will promote positive mental wellbeing for all, reduce stigma around mental health, and target help and support at the earliest opportunity to those that need it most. Mental resilience, well-being and the prevention of mental illness is not just – or even primarily – an issue for NHS services. We recognise that mental health prevention needs to focus on the needs of the whole person and the wider determinants of health including social

		isolation, physical health and cultural needs.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	We will aim to support people in the community wherever we can, working at 'neighbourhood' level with schools, GPs and voluntary and community services.
Ensure we maintain financial balance as a system and achieve our financial plans	☒	By developing integrated approaches to health and social care, including mental health the MHCC will have oversight of financial plans across the system.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	The approach takes the form of a commitment: 'to working together to develop a whole system, all-age approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners.' We will improve access to mental health support and services, to reflect the diversity of our communities, the most vulnerable and those whose mental health problems are masked by other needs
Empower patients and residents	☒	We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services

Specific implications for City

The new strategy sets out a shared vision, approach and priorities for mental health services across City and Hackney. It will benefit residents, workers, the most vulnerable (including the homeless) in the City of London.

Specific implications for Hackney

The new strategy sets out a shared vision, approach and priorities for mental health services across City and Hackney. It will benefit residents, workers, the most vulnerable (including the homeless) in Hackney.

Patient and Public Involvement and Impact:

The Mental Health Voice Service User Committee are members of the Mental Health Coordinating Committee and sit on the Editorial Board.

Service User reps led on the Personalisation and Co-production section of the strategy

and as editorial board members provided input and steer on all other areas.

Clinical/practitioner input and engagement:

A range of local providers have been consulted as part of the workstream consultation stage. A VSO rep sits on the MHCC.

The CCG Mental Health Clinical Lead has inputted and shaped the strategy with further input from clinicians across the four workstreams. ELFT are members of the MHCC.

Equalities implications and impact on priority groups:

The final version of the strategy will be informed by an Equality Impact Assessment. Equalities implications impact on the following priority groups:

Age

Dementia is one of the main causes of disability in later life. Data from NHS Digital indicates that, as of July 2019, City & Hackney CCG had an estimated prevalence of dementia for people over 65 of 1,359 with a diagnostic rate of 70% (952 people).

Mitigation: Launch of Dementia Service in October 2019 which aims to hold patients from point of diagnosis to end of life or out of borough placement.

Disability

A quarter of the general population have problems with their mental health at some point in their life. In autistic people, this number is much higher with almost 80% of autistic adults experiencing mental health issues during their lives.

Mitigation: We will improve access to mental health support for autistic people including ensuring staff are trained in autism awareness and how to make reasonable adjustments to services.

Race

40% of ELFT inpatients detained under the Mental Health Act were from an african/afro-caribbean heritage background. There is a concern about the over-representation of black men within crisis and forensic services.

Mitigations:

- ✓ We will develop effective pathways and provision for key equalities groups, with a focus on young black boys and men through links with communities, community champions and community organisations. We will appoint Young Black Men leads within the local IAPT service.
- ✓ We will monitor equalities in assessing delivery of our strategic priorities and actions and performance of our services and those we commission.
- ✓ We will ensure under-represented groups are better represented in the workforce
- ✓ We will ensure that services meet the needs of under-represented groups and do not prevent barriers to access.
- ✓ We will build on the Improving Outcomes for Young Black Men Programme led by the London Borough of Hackney and HCVS (working closely with ELFT's BME access team).

Sexual orientation

Evidence suggests people identifying as LGBT are at higher risk of experiencing poor mental health. Members of the LGBT community are more likely to experience a range of mental health problems such as depression, suicidal thoughts, self-harm and alcohol and substance misuse.

Mitigations:

- ✓ We will develop effective pathways and provision for key equalities groups, with a focus on the LGBTQ community through links with communities, community champions and community organisations. We will appoint a LGBTQ lead within the local IAPT service.
- ✓ We will monitor equalities in assessing delivery of our strategic priorities and actions and performance of our services and those we commission.
- ✓ We will ensure under-represented groups are better represented in the workforce.
- ✓ We will ensure that services meet the needs of under-represented groups and do not prevent barriers to access.

Safeguarding implications:

The strategy should improve adult safeguarding through integrated working arrangements at the neighbourhood level.

Impact on / Overlap with Existing Services:

Mental Health service provision across the NHS and Local Authority, acute, GP and community services. This will also include local voluntary community sector organisations.

Main Report

Background and Current Position

The *City and Hackney Mental Health Strategy 2019-23* has been developed as part of work being led by the Integrated Commissioning Board to develop integrated approaches to health and social care, including mental health. Development has been overseen by a Mental Health Co-ordinating Committee bringing together partners, and supported by a joint editorial group, with service user representation.

It should be read alongside other key strategies. These include the Joint Health and Wellbeing Strategies, Suicide Prevention Strategies for both the City of London and Hackney, our Local Transformation Plan for Child and Adolescent Mental Health Services, the East London Health and Care Partnership (ELHCP) Operating Plan, NHS Five Year Forward View, NHS Long Term Plan, Voluntary and Community Sector Strategy 2019-22 and the City and Hackney Autism Strategy (final version due October 2019).

The *vision* s that: *'Everyone will enjoy good mental health in the City and Hackney with access to the right care at the earliest opportunity when they need it, delivered as close to their local community as possible'*.

The *approach* takes the form of a commitment: *'to working together to develop a whole system, all-age approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners.'*

The five strategic priorities are:

- Prevention: 'We will promote positive mental wellbeing for all, reduce stigma around mental health, and target help and support at the earliest opportunity to those that need it most'.

- *Access*: 'We will improve access to mental health support and services, to reflect the diversity of our communities, the most vulnerable and those whose mental health problems are masked by other needs'.
- *Neighbourhoods*: 'We will aim to support people in the community wherever we can, working at 'neighbourhood' level with schools, GPs and voluntary and community services'.
- *Personalisation and co-production*: 'We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services'.
- *Recovery*: 'We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks'.

The four *building blocks* to support delivery of the priorities are: *people* and workforce development; *engagement* with experts by experience, practitioners and partners; *data and digital*; and *evidence-based policy* and practice.

Key areas of activity will include:

- Improving access to care and support for people with complex needs;
- An inclusive approach informed by an Equality Impact Assessment;
- A greater role for GP and primary care services and the voluntary sector;
- support people in the community wherever we can, working at 'neighbourhood' level, with schools, GPs and voluntary and community services;
- Increased use of personal health budgets; and
- Improved housing and employment support for people in recovery.

Delivery and governance

The MHCC will be accountable for the delivery of the strategy, monitoring progress against an Action Plan. Further political oversight and accountability will be provided by the City of London and Hackney Health and Wellbeing Boards. The MHCC will co-ordinate an annual review of progress and developments, to ensure we are responding to new learning, challenges and opportunities.

It is our expectation that this strategy and the accompanying Action Plan (see Appendix 2) will be naturalised within the planning and strategic processes of partner organisations as appropriate, to inform and drive delivery of objectives for which they have a lead responsibility.

The final version of the strategy will be informed by an Equality Impact Assessment.

Supporting Papers and Evidence:

Appendix 1: Mental Health Strategy Needs Analysis Appendix 2: Draft Mental Health Strategy Action Plan 2019-23 Appendix 3: City and Hackney CAMHS Transformation Plan (Phase 3): Implementation (2019-20) Appendices embedded within Mental Health Strategy document.

Sign-off:

[Papers for approval by the ICBs must be signed off by the appropriate senior officers. Any paper with financial implications must be signed by the members of the Finance Economy Group. If there are any legal implications which require consultation with legal counsel, please make reference to that below. Please ensure you have appropriate sign off for your report, along with the papers. Papers which have not been signed-off by the appropriate officers will not be considered] Workstream SRO: [*insert name and title*] London Borough of Hackney: [*insert name and title*] City of London Corporation: [*insert name and title*] City & Hackney CCG: [*insert name and title*]

Mental Health Strategy

Integrated Commissioning Board
10 October 2019
Dan Burningham, Mental Health Programme Director,
City and Hackney CCG

Executive Summary and Key Points

Mental Health Strategy 2019-23

Our Vision

"Everyone will enjoy good mental health in the City and Hackney with access to the right care at the earliest opportunity when they need it, delivered as close to their local community as possible"

Our Approach

"We are committed to working together to develop a whole system, all-age approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners"

Executive Summary and Key Points

City and Hackney Mental Health Strategy 2019 -23

- This strategy sets out our priorities for mental health support and services across City and Hackney for 2019-2023.
- The strategy has been developed collaboratively, bringing together the City of London Corporation, London Borough of Hackney, NHS, local government, voluntary and community sector and other partners, working co-productively with mental health service users.
- It sets out a vision, priorities and direction of travel, and builds in the flexibility to develop them collaboratively going forward.

The five strategic priorities are:
Prevention: 'We will prevent people from developing mental health problems in the first place, and provide help at the earliest opportunity when they do'.
Access: 'We will improve access to mental health support and services, to reflect the diversity of our communities, the most vulnerable and those whose mental health problems are masked by other needs'.

Neighbourhoods: 'We will aim to support people in the community wherever we can, working at 'neighbourhood' level with schools, GPs and voluntary and community services'.

Personalisation and co-production: 'We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services'.

Recovery: 'We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks'.

Background

- The *City and Hackney Mental Health Strategy 2019-23* has been developed as part of work being led by the Integrated Commissioning Board to develop integrated approaches to health and social care, including mental health.

- Development has been overseen by a Mental Health Co-ordinating Committee bringing together partners, and supported by a joint editorial group, with service user representation.

- It considers mental health and wellbeing as part of the new integrated care system for City and Hackney, which is organised around four workstreams: '*prevention*', '*planned care*', '*unplanned care*' and '*children, young people, families and maternity'*. The strategy sets out the approach to mental health across this system and seeks to ensure 'parity of esteem' with physical health in all that we do.

Who benefits from this project?

- The strategy assesses the needs of our population, maps the challenges, identifies the opportunities, and explains how we will work collaboratively as partners and with service users to deliver our priorities, as well as how we will monitor our progress.

- It considers how we will support the mental health and wellbeing of:

    - Our residents
    - The most vulnerable – e.g. the homeless and rough sleepers
    - All sections of our diverse populations
    - People who work in the City of London and Hackney.

- It also explains how we will develop and apply the 'neighbourhood model' to mental health in City and Hackney, supporting people in their homes and communities wherever possible and mobilising community assets, whether that's carers and friendship networks, the local GPs surgery or voluntary and community sector services.

- It has been informed by an *Equality Impact Assessment* (EQIA), which will shape our approach to addressing the diversity of our communities going forward.

How do you propose to implement this work?

- Implementation will be overseen within the Integrated Commissioning System by the Mental Health Coordinating Committee and by the Core Leadership Groups for the four ‘workstreams’.

- The Mental Health Coordinating Committee will be accountable for the delivery of the strategy, monitoring progress against an Action Plan. A draft Action Plan has been shared with ICB.

- Progress will be reported to the Health and Wellbeing Board at least annually, as well as to the City of London Community and Children’s Services Committee.

CITY AND HACKNEY MENTAL HEALTH STRATEGY 2019-23

Contents

Executive Summary

Our vision: *'Everyone will enjoy good mental health in the City and Hackney with access to the right care at the earliest opportunity when they need it, delivered as close to their local community as possible'.*

Our approach: '*We are committed to working together to develop a whole system, all-age approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners'.*

Our five strategic priorities:

Prevention: *We will promote positive mental wellbeing for all, reduce stigma around mental health, and target help and support at the earliest opportunity to those that need it most.*	**Access:** *We will improve access to mental health support and services, to reflect the diversity of our communities, the most vulnerable and those whose mental health problems are masked by other needs*	**Neighbourhood** *We will aim to support people in the community wherever we can, working at 'neighbourhood' level with schools, GPs and voluntary and community services.*	**Personalisation and co-production:** *We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services.*	**Recovery:** *We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks.*
We will: • Develop a 'health in all policies' approach • Implement a local transformation plan for CAMHS services • Work with employers on workplace mental health and wellbeing • Help people at the earliest opportunity • Prevent suicide	We will • Expand open access to support • Improve access for people with complex needs like addictions and homelessness, physical health problems and a history of offending. • Work with community organisations to reach under-represented groups and protected characteristics and ensure earlier access to mental health pathways. • Improve access for autistic people	We will • Develop the role of GP and primary care services • Develop multi-disciplinary teams around the person in neighbourhoods • Develop Community Dementia support in neighbourhoods • Develop step up and integrated assessment	We will: • Expand the use of personal budgets • Develop service user led goals and care plans • Develop personalised online support • Involve service users in the commissioning, design and monitoring of local mental health services	We will • Develop the role of the Recovery College • Improve housing support and accommodation pathways • Support service users into training and work • Help people to build and maintain social networks

Our building blocks:

People: *Develop our workforce capacity and skills and support carers, peer mentors and volunteers*	**Engagement:** *Listen and learn by working with experts by experience, practitioners and partners*	**Data and digital:** *Share data, building a shared evidence base and develop digital options*	**Evidence-based policy**: *Be guided by research and best practice, and monitor the impact of what we do*

1. Introduction

1.1. This strategy sets out our priorities for mental health support and services across City and Hackney for 2019-2023. It has been developed and will be implemented as part of our Integrated Care System. It provides a framework to shape, inform and support improvements in mental health care in City and Hackney. It sets out a vision, priorities and direction of travel, and builds in the flexibility to develop them collaboratively going forward.

1.2. It should be read alongside other key strategies. These include the *Joint Health and Wellbeing Strategies, Suicide Prevention Strategies* for both the City of London and Hackney, our *Local Transformation Plan* for Child and Adolescent Mental Health Services, the East London Health and Care Partnership (ELHCP) Operating Plan, NHS Five Year Forward View, NHS Long Term Plan, Voluntary and Community Sector Strategy 2019-22 and the City and Hackney Autism Strategy (final version due September 2019).

What is covered by this strategy?

1.3. The strategy assesses the needs of our population, maps the challenges, identifies the opportunities, and explains how we will work collaboratively as partners and with service users to deliver our priorities, as well as how we will monitor our progress.

1.4. It considers how we will support the mental health and wellbeing of:

- Our residents
- The most vulnerable – e.g. the homeless and rough sleepers
- All sections of our diverse populations
- People who work in the City of London and Hackney.

It is also intended as a contribution to the development of national and pan-London mental health policy.

1.5. It considers mental health and wellbeing as part of the new integrated care system for City and Hackney, which is organised around four workstreams: '*prevention*', '*planned care*', '*unplanned care*' and '*children, young people, maternity and families'*. The strategy sets out the approach to mental health across this system and seeks to ensure 'parity of esteem' with physical health in all that we do.

1.6. It also explains how we will develop and apply the 'neighbourhood model' to mental health in City and Hackney, supporting people in their homes and communities

wherever possible and mobilising community assets, whether that's carers and friendship networks, the local GPs surgery or voluntary and community sector services.

What is not covered in this strategy?

1.7. We are committed to developing an all-age approach to mental health and wellbeing in City and Hackney, and are working through the Integrated Care System to improve transitions from adolescent to adult services, particularly for our most vulnerable young adults.

1.8. Our plans are set out in detail in the City and Hackney local transformation plan (LTP) for Children and Adolescent Mental Health Services (CAMHS). The Children, Young People and Maternity Workstream within the City and Hackney integrated care system is overseeing the development and implementation of the LTP, as well as looking at other key areas of mental health provision, including peri-natal care and support. A brief summary of our approach to children and young people is provided as appendix 2 of this document.

How was the strategy developed?

1.9. We have developed this strategy collaboratively, bringing together the City of London Corporation and LB Hackney, and NHS, local government, voluntary and community sector and other partners, working co-productively with mental health service users.

1.10. It has been informed by an *Equality Impact Assessment* (EQIA), which will shape our approach to addressing the diversity of our communities going forward.

1.11. It has been overseen by a Mental Health Coordinating Committee (MHCC) of senior officers, providers and service users, supported by a Joint Mental Health Action Team, as part of the City and Hackney Integrated Care System. The MHCC will be accountable for the delivery of the strategy, monitoring progress against an Action Plan. Further political oversight and accountability will be provided by the City of London and Hackney Health and Wellbeing Boards. The MHCC will co-ordinate an annual review of progress and developments, to ensure we are responding to new learning, challenges and opportunities.

1.12. It is our expectation that this strategy and the accompanying Action Plan (see Appendix 2) will be naturalised within the planning and strategic processes of partner organisations as appropriate, to inform and drive delivery of objectives for which they have a lead responsibility.

2. Vision, approach and priorities

2.1. Our local vision is that *'Everyone will enjoy good mental health in the City and Hackney with access to the right care at the earliest opportunity when they need it, delivered as close to their local community as possible.'*

2.2. Our approach will be to work together *'to develop a whole system approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners'*.

2.3. Our focus will be on five strategic priorities:

- ✓ Prevention: *We will promote positive mental wellbeing for all, reduce stigma around mental health, and target help and support at the earliest opportunity to those that need it most.*
- ✓ Access: *We will improve access to mental health support and services, reaching out to reflect the diversity of our communities, the most vulnerable and those whose mental health needs are masked by other needs or complexity.*
- ✓ Neighbourhood: *We will aim to support people in the community wherever we can, working at 'neighbourhood' level, with schools, GPs and voluntary and community services.*
- ✓ Personalisation and co-production: *We will continue to shift power and control to service users, giving them control of their own care and recovery, and working with them to identify their goals.*
- ✓ Recovery: *We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks.*

2.4. We will also focus on four building blocks, which will underpin our strategic priorities:

- ✓ People: *We will develop our workforce capacity and skills, recognise and support the role of carers and work in partnership with peer mentors and volunteers.*
- ✓ Engagement: *We will listen and learn by working with experts by experience, practitioners and partners*
- ✓ Data and digital: *We will improve arrangements for sharing and learning from our data and be innovative in developing the use of digital and technological resources.*
- ✓ Evidence-based policy: *We will be guided by research and best practice, and monitor the impact of what we do*

2.5. We do not underestimate the challenges that we will face in the next four years, and the need to be *both* realistic *and* innovative. They include rising demand for mental health care at a time of increasing pressures on NHS and local government budgets. By working together, intervening earlier, empowering 'experts by experience', removing barriers to support and moving to neighbourhood models of care, we believe that we

have an opportunity to improve outcomes in a way that will also help us to manage the pressures on budgets, resources and services.

3. Where are we now? The strategic environment

National policy

3.1. Our approach in City and Hackney is shaped by NHS England's *Five Year Forward View for Mental Health* (2016), which champions the principle of 'parity of esteem' for mental and physical health and identifies three Priorities for Action:

- *A seven-day NHS – right care, right time, right quality* – e.g., community-based crisis care
- *An integrated mental and physical health approach* – e.g., better physical health for people with severe mental health problems and better mental health for people who are physically unwell
- *Promoting good mental health and preventing poor mental health* - e.g., mentally healthy communities and improving employment rates.

3.2. This strategy also addresses priorities set out in the *NHS Long Term Plan* (2019):

- *The neighbourhood model* with care delivered at neighbourhood level by multi-disciplinary teams of GPs, other primary care services, pharmacies and through the mobilisation of community services and assets.
- *Personalised care,* including the use of online therapies and digital support and the roll out of Personal Health Budgets. To give people greater choice and control over their care.
- *Severe Mental Illness* (SMI) *and complex needs*, with a focus on integrating primary and community mental health services to improve access to psychological therapies, medicines management, physical health care, trauma informed care, employment support, access to drug and alcohol treatment and support for self-harm. 'This includes maintaining and developing new services for people, who have the most complex needs.'
- *Reduced A&E use and admission by people with SMI* with alternative support for those in crisis including sanctuaries and safe havens, crisis cafes, crisis houses, acute day services, host families and Clinical Decision Units.
- *Children and Young People* with a focus on the Green Paper *Transforming Children and Young People's Mental Health* (2017), with an enhanced role for schools and a comprehensive offer for 0-25-year olds to support transition to adulthood.

3.3. The strategy will support the aims of the NHSE's London Mental Health Compact for access to inpatient services launched in April 2019. The Compact sets targets for timely access to mental health crisis services.

3.4. We will also build on local arrangements to support partnership responses to people in mental health crisis through the *Mental Health Crisis Care Concordat* (2014). We will adopt Public Health England's *Prevention Concordat for Better Mental Health* in City and Hackney to support our focus on prevention and early intervention. Our politicians will provide leadership with designated Mental Health Champions at the City Corporation and Hackney, engaging with the Local Authority Mental Health Challenge.

4. Where are we now? Understanding the needs of our communities

4.1. City and Hackney provides many excellent mental health, public health and social care services that are highly rated and, in some instances, have received national recognition. The Voluntary, Community Social Enterprise (VCSE) sector in City and Hackney plays a vital role in maintaining strong local communities, reaching residents that statutory services may struggle to reach and empowering and supporting community and individual resilience.

4.2. Our services face challenges, including:

- A relatively high number of people with severe and enduring mental health problems many of whom are in primary care settings and require ongoing support.
- A relatively high number of people with complex problems who are not accessing the right services either because their mental health problems are undiagnosed or because the different kinds of care they need are not well integrated. Many are high frequency users of A&E and primary care. Mental health issues may be masked by physical complaints, addiction, homelessness and chaotic lifestyles.
- In our richly diverse area some communities are less able to access care and support than others.

Mental health in City and Hackney: Key Numbers

Fifth highest rate of psychotic and bipolar disorders in England, with 4,500 on the Serious Mental Illness (SMI) register.

Around 2,200 engaging with specialist mental health services in City and Hackney in the previous 12 months.

Three quarters of people with SMI managing their condition in the community supported by GP and primary care services, often with voluntary and community sector involvement.

Smoking rates among people with SMIs are 36% higher than the general population, and obesity rates 50% higher.

Life expectancy is between 8 and 18 years lower than for the general population.

An estimated 11,000 people in City and Hackney with a personality disorder

6,490 people in City and Hackney with severe and enduring mental health problems entered secondary care services in 2017-18, with 1,089 admitted as in-patients.

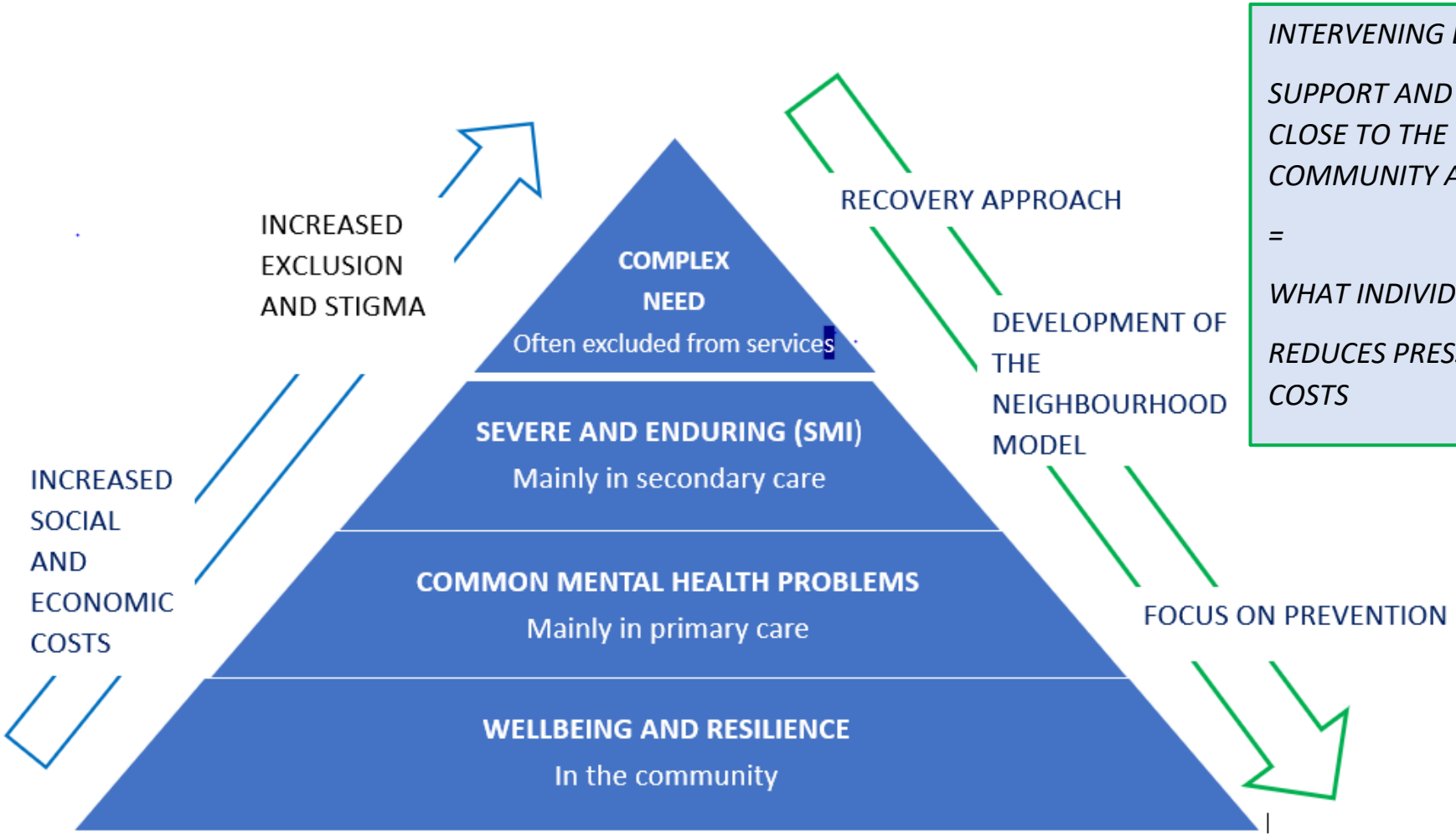
33,000 people in City and Hackney are experiencing depression and/or anxiety disorders at any one time

14,000 people are receiving repeat prescriptions of anti-depressants and around 1 in 5 accessing 'talking therapies' through the IAPT programme

The number of residents with dementia is expected to increase by one third by 2025, from 1,290 to 1,890

See appendix 1 for a more detailed needs analysis for City and Hackney

Implementing our approach to meet the needs of our population



INTERVENING EARLIER

SUPPORT AND CARE AS CLOSE TO THE COMMUNITY AS POSSIBLE

=

WHAT INDIVIDUALS WANT

REDUCES PRESSURES AND COSTS

5. Delivering our Priorities

Our Priorities 1: Prevention

We will promote positive mental wellbeing for all, reduce stigma around mental health, and target help and support at the earliest opportunity to those that need it most

Why it matters

5.1. Promoting positive mental health for all, reducing stigma around mental health, and targeting help and support at the earliest opportunity for those who need it most, will improve the resilience of communities and improve outcomes for individuals, reducing the pressures and associated costs to specialist mental health services, as well as receiving the wider economic and social gains of good mental health and wellbeing (e.g. better employment rates, educational outcomes, and people being able to reach their full potential as members of society).

We also have a responsibility for suicide prevention and recognise the importance of this priority given the devastating and wide-ranging impact suicide has within the community, as well as to the lives of family members, friends, peers, and services.

What we will do

5.2. Mental resilience, well-being and the prevention of mental illness is not just – or even primarily – an issue for NHS services. We recognise that mental health prevention needs to focus on the needs of the whole person and the wider determinants of health including social isolation, physical health and cultural needs. Furthermore we recognise the vital contribution of the VCSE sector, schools, businesses, employers, criminal justice agencies, the built and natural environments and services like planning, transport, leisure and culture and other local groups in realising this aim.

KEY ACTIVITIES	**WE WILL …. (See Appendix 2 Action Plan for detailed targets)**
Linking mental health to the wider determinants	✓ Develop our built and green environment to promote mental health ✓ Work across service departments to promote their role in mental health and to develop this (e.g., planning, transport, leisure and culture) ✓ Join and apply the national Prevention Concordat for Better Mental Health ✓ Develop a dementia friendly community across City and Hackney ✓ Improve the assessment of physical health for people with mental health problems and access to supportive interventions like Core Sports ✓ Improve the identification of loneliness through a biopsychosocial approach to neighbourhood mental health assessments and improve supportive interventions in the VCSE sector. Improve the range of supportive interventions ✓ Support the community sector-resident led support

Early years, families and young people	✓ Develop perinatal support ✓ Develop designated senior mental health teams in schools and Mental Health Support Teams for early intervention and ongoing help at school ✓ Develop our offer to children with Special Educational Needs and Disabilities ✓ Implement the third phase of our Local Transformation Plan for Children and Young People's Mental Health Services (CAMHS)
Workplace	✓ Work with businesses and employers on workplace mental health ✓ Support NHS workforce to access mental health wellbeing support ✓ Support national campaigns like Release the Pressure
Mental health crisis and suicide prevention	✓ Develop and implement the City and Hackney suicide prevention strategies ✓ Samaritans-led Suicide Prevention awareness raising Training, working with employers ✓ Strengthen our crisis pathway with more accessible services that reach beyond statutory mental health services
Awareness and Information	✓ Improving online information and use of digital channels and social media ✓ Develop communications campaigns to support mental wellbeing
Get support to people quicker	✓ Develop open access and low threshold services (see priority 2 – Access) ✓ Ensuring everyone in the City and Hackney with dementia can be diagnosed early with access to the right level of care at the right time

CASE STUDIES - SOME EXAMPLES of our work on PREVENTION

Preventing suicide …

The City of London Street Triage team works with police and aims to reduce suicide and unnecessary admissions. Other initiatives include the Crisis Café, rolling out Samaritan-led suicide prevention training and reducing the environmental risks (e.g. by signposting people to specialist help services on bridges and railway platforms). When suicides do occur, the circumstances and lessons are subject to review by Safeguarding Board, so lessons can be learned.

Coping with life events

LB Hackney is publishing a series of 'Life Events' support packs that provide ideas, advice, contact numbers and links to videos and online resources to help people to stay mentally resilient when they face big changes in their lives.

Supporting mental health in the workplace in City and Hackney The City Corporation's Business Health network is a community and online resource for business leaders committed to improving the health and safety of their workforce. A recent survey of City employers found that mental health was their number one priority, and this is being reflected in the planning and development of network resources, events and activities from 2019.

Five ways to thrive – simple mental wellbeing tips for everyone

Across City and Hackney we are embedding our local 'Five Ways to Thrive' initiative into our communications resources, for a variety of audiences, including our residents, businesses and workers. This is based on the Five Ways to Mental Wellbeing Model that was developed by the New Economics Foundation. The five ways to thrive are to 'connect', 'be active', 'take notice', 'keep learning' and 'give'.

Tackling social isolation and loneliness …

The City and Hackney Safeguarding Adults Board is helping to lead and co-ordinate activity to address loneliness and social isolation among our residents. The Connect Hackney initiative has focused on social connectivity for older adults in the Borough. The City Corporations Social Wellbeing Strategy has driven a range of initiatives, including a Community Builders programme using resident volunteers on City Estates to connect people to each other and to services on the City.

6. Our priorities 2: Access

We will improve access to mental health support and services, reaching out to reflect the diversity of our communities, and to the most vulnerable.

Why it matters

6.1. It matters because needs can remain unidentified and untreated where people are unable to access care and support, often with serious negative impact on people's lives (e.g., alcohol and drug problems, loss of employment, debt, housing problems and homelessness), families and communities (e.g. family breakdown, crime or anti-social behaviour) and other services (e.g. A&E departments). People with complex needs have some of the worst health, wellbeing and social outcomes. However, our current services, which are often focused on a particular range of need often lack the experience, skill or capacity to address complex needs. The result is many people with complex are unable to access mental health services despite the fact that the issues they face may be partly a consequence of underlying mental health problems.

6.2. In City and Hackney we have high numbers of A&E, ambulance and 111 frequent attenders, placing significant additional pressures on NHS services. Evidence suggests that undiagnosed mental health problems are often a factor in complaints about physical illnesses. Untreated mental health problems are also a barrier to recovery from addictions and to pathways out of homelessness. People with complex needs can find themselves excluded from and passed between services.

6.3. It also matters because some groups in our diverse communities are under-represented in our services, including young black boys and men, LGBTQ people and older adults. Furthermore, whilst some BME groups such as young black men are under-represented in terms of engagement in earlier stages of the pathway e.g. psychological therapies access, they are over represented at the more acute end in terms of inpatient admissions and the use of the Mental Health Act.

6.4. We know that mental health problems are more common among autistic people and this group can experience a number of potential barriers to accessing services. An autistic person may not be able to describe their symptoms effectively, either due to their autism or perhaps as a consequence of co-existing anxiety or depression.

Key figures

Nearly 275 people in City and Hackney have attended hospital and A&E services 10 times or more in a year without a clear physical cause, over 3,000 attendances.

In Hackney in 2017-18, 58 of 118 rough sleepers (49%) had mental health needs

In the City of London, 151 of 265 rough sleepers (57%) had mental health needs, The Mental Health Foundation reported that in 2014, 80% of homeless people in temporary accommodation, accommodation services and people sleeping rough in England said they had mental health issues, with 45% having been diagnosed with a mental health condition.

15,169 patients in City and Hackney who have diabetes, of which 2,471 (18%) have uncontrolled diabetes.

The lifetime prevalence of anxiety and depression among autistic adults is estimated to be 42% and 37% respectively.

Only 15% of the street homeless population across City and Hackney have no identified alcohol, drug or mental health need. In City and Hackney, 386 people who started drug and/or alcohol treatment in 2017-18 had a mental health need (over 40%) – over a third of this group were receiving no treatment.

This is also likely to be a significant underestimate (UK studies suggest the prevalence rates for co-existing mental health and substance misuse problems within mental health services are between 32% and 46%, while rates have been recorded at 75% in drug services and 86% in alcohol services. Furthermore, a history of alcohol or drug use is also recorded in 54% of all suicides).

40% of ELFT inpatients detained under the Mental Health Act were from an african/afro-caribbean heritage background.

What we will do

We will develop 'open access' mental health support and focus on addressing the (often unidentified) mental health needs of four key groups who may be excluded from services: frequent A&E, ambulance and 111 services; the homeless and rough sleepers; people with and in recovery from addictions; and equalities groups.

KEY ACTIVITIES	WE WILL …. (See Appendix 2 Action Plan for detailed targets)
Open access	✓ Introduce whole school approaches to mental health and wellbeing ✓ Develop our no wrong door approach to CAMHS services ✓ Develop open access services like the Recovery College ✓ Provide timely access to high quality crisis services in line with Compact ✓ Expand immediately accessible crisis services in City and Hackney ✓ Improve access for people in crisis through mental health street triage ✓ Work jointly with the VCSE sector in improving access particularly BAME groups.
Physical health and mental health	✓ Develop assessment, referral and integrated care pathways to diagnose and address the mental health needs of people presenting with physical illness ✓ Target action to reduce numbers of frequent users of A&E, ambulance and mental health services by addressing undiagnosed mental health need ✓ Build on our programme of physical health reviews for people with SMIs, by increasing their frequency and strengthening the support offer for those at risk of physical illness ✓ Pilot sport and healthy eating programmes for people with SMIs
Dual diagnosis and complex need	✓ Invest in Multiple Needs Service for those with multiple and complex needs ✓ Develop communication and partnership working across all organisations that work with local people who have complex needs, including providing relevant training to enable them to work flexibly across service and professional boundaries ✓ Jointly develop a new substance misuse contract that better integrates substance misuse and mental health services including: the integration of substance misuse into psychiatric liaison; a seamless pathway between mental health services and substance misuse services and ensuring that people with substance misuse problems have access to support for their mental health needs. ✓ Improve the offer of tailored support for people, who are homeless or sleeping rough taking account of chaotic lifestyles and complex need integrated mental health, substance misuse and physical health services ✓ Develop the 'housing first' approach to rough sleeping ✓ Work with businesses to improve understanding and address the links between alcohol and drug misuse and mental health in the workplace

	✓ Improve access to mental health support for autistic people including ensuring staff are trained in autism awareness and how to make reasonable adjustments to services
Addressing diversity	✓ Develop effective pathways and provision for key equalities groups, with a focus on young black boys and men, the LGBTQ community and older adults through links with communities, community champions and community organisations ✓ Monitor equalities in assessing delivery of our strategic priorities and actions and performance of our services and those we commission ✓ Ensure under-represented groups are better represented in the workforce ✓ Ensure that services meet the needs of under-represented groups and do not prevent barriers to access.

CASE STUDIES – SOME EXAMPLES of our approach to ACCESS

Physical and mental health

City and Hackney is piloting a new service for people who make intensive use of A&E or London ambulance services, where physical illness may reflect underlying psychological issues. The service will be accessible to anyone who is a frequent user of these services, regardless of whether they have a formal mental health diagnosis and offer psychological, emotional and practical support.

Releasing the pressure …

The Dragon Café welcomes anyone who is feeling the pressures of work or life in and around the City of London. It is hosted in Shoe Lane Library in the City, and offers a programme of activities designed to release pressure, reduce stress and build resilience. It is free, open to all and with no requirement to register or book in advance.

New Mental Health Centre ….

The City Corporation is commissioning a provider for a new Mental Health Centre, offering rent-free premises in the Square Mile for over three years, to provide low cost sessions for low income workers and residents, and long-term therapies that are not readily available through the NHS. It is intended that providers will charge those most able to pay and offer subsidised sessions to those on lower wages or not able to pay for other reasons.

Access to local community providers

Bikur Cholim, a local community organisation provides IAPT talking therapy service to the Charedi Orthodox Jewish community.

Hackney Caribbean Elderly Organisation Memory Wellbeing project provides social and emotional support to people living with dementia, their carers and families predominantly from the BME communities.

A free advice service for people in the City of London

The City Advice service (commissioned by Public Health and provided by Toynbee Hall) provides free and expert advice to City residents, students and workers on a range of issues, including debt, housing, relationship and legal issues.

Supporting the most vulnerable …

A dual diagnosis treatment pilot at the Greenhouse Clinic has been commissioned targeting people with mental health and substance misuse problems, who are likely to be excluded from mental health services due to their drug or alcohol misuse. There will be specialist mental health practitioners in both the Greenhouse Clinic and the Hackney Recovery Service, who will work to identify and provide appropriate support to this cohort. The pilot will inform the re-commissioning of an integrated adult substance misuse services.

Helping people in crisis get timely help…

After a successful pilot the City Corporation, City of London Police and City and Hackney CCG are funding a Mental Health Triage System to operate in the City for seven days a week. Mental health professionals accompany police on patrol and can intervene where people are experiencing a crisis that might otherwise lead to them being 'sectioned' under the Mental Health Act. By getting the right support in the community, this improves outcomes for individuals and reduces the pressures on acute and crisis services.

7. Our priorities 3: Neighbourhood

Why it matters

We will aim to support people in the community wherever we can, working at neighbourhood level with schools, GPs and voluntary and community services

7.1. The City and Hackney Integrated Care System is implementing a neighbourhood model of health and social care, and this is also at the heart of the *NHS Long Term Plan*. This model will align local services at a neighbourhood level with responsibility for population based health covering 30,000-50,000 people. NHS England is making £4.5 billion available nationally to support the development of this model locally over the next five years. City and Hackney were recently (July 2019) awarded NHSE non-recurrent transformation funding in 2019-20 and 2020-21 to deliver a neighbourhood mental health model.

7.2. Shifting the balance of care into neighbourhoods offers significant opportunities for improved integration between primary and secondary care, between social care and health services and between mental health and physical health services. Furthermore we want to create a more effective bridge between statutory services and VCSE organisations in order to create a more effective wraparound for people with complex and enduring mental health problems. To support this approach we aim to create blended neighbourhood mental health teams which include primary care, secondary care, social care and VCSE staff.

7.3. City and Hackney has comparatively advanced primary care mental health services. They include an Enhanced Primary Care (EPC) and a Primary Care Liaison (PCL) service, along with a Primary Care Psychotherapy Consultation Service. We also have a high performing IAPT service, delivering 'talking treatments' with a focus on common mental health problems, particularly anxiety and depression. However, there are still many gaps particularly for people with complex or severe and enduring mental health problems, who are outside a secondary care setting.

7.4. Working with the voluntary and community sector, and further integrating local authority and NHS services, we also have plans to improve the level of social support available in GPs surgeries and other primary care settings – this could include, for example, help with debt and financial management, housing and employment support.

7.5. There is a concern about the over-representation of black men within crisis and forensic services. Developing the neighbourhood model provides an opportunity to start to address this, by working closely with local communities and providing an integrated wrap around service that should be well adapted to address the social determinants that impact the emotional wellbeing of this group. We will build on young black men

work led by the London Borough of Hackney and HCVS (working closely with ELFT's BME access team).

What we will do

7.6. Building on the emerging neighbourhood model we will shift the balance of care provision from secondary to primary care by strengthening community-based provision in primary care practices, schools and other community organisations, developing care navigation at local level and creating inter-organisational teams and approaches.

KEY ACTIVITIES	WE WILL …. (See Appendix 2 Action Plan for detailed targets)
Neighbourhood teams	✓ Create neighbourhood based mental health teams in each neighbourhood, which will work as part of the wider neighbourhood MDT and will: assess for enhanced primary care and non-urgent secondary care mental health services; support service user centred recovery plans; co-ordinate packages of support around the service user; provide coaching and reviews.
Focal points for care	✓ Develop the roles of community connectors , peer support workers, social prescribers and coaches in an integrated way to create a 'seamless services', which supports diversity and connects service users to their community ✓ Increase the access and provision of step up services for complex, severe and enduring mental health problems in neighbourhoods ✓ Reduce the unnecessary use of secondary care mental health services ✓ Ensure everyone diagnosed with dementia has a named navigator from diagnosis to end of life where VSO are a key part of the community wraparound support ✓ Develop transition services and pathways in the community, especially for young people falling out of conventional mental health services
Culture, skills and confidence	✓ Implement recovery and co-production models for neighbourhood mental health provision ✓ Establish a system of joint GP-Psychiatrist involvement in anti-psychotic medication reviews ✓ Continue to improve the care provided in primary care and through community organisations and networks through mental health training and awareness initiatives
Dementia	✓ Create a neighbourhood-based dementia service with continuity of care from diagnosis to death

CASE STUDIES – SOME EXAMPLES of our approach to NEIGHBOURHOODS

Stepping down …

The City and Hackney Enhanced Primary Care (EPC) Service supports people with severe and enduring mental health problems to 'step' down from specialist, secondary NHS services and be supported in the community, with regular GP reviews and input from a mental health liaison worker. Since widening access to more people with more complex problems - like personality disorders – it is now working with 500 to 600 people a year. Recovery Plans, produced with service users to reflect their goals, will be developed so they can be carried over as people step down into primary care services. We want to expand to cover discharge packages for a great number of people - c6,000 per annum.

… And Stepping Up

For Assessment and Brief Treatment we want to expand and provide more ongoing support for people with severe and enduring mental health problems including people with psychotic bipolar, personality disorders and trauma.

We want to explore and pilot models for a step-up service to provide timely interventions in the community for people with severe and enduring mental health issues, who may otherwise need secondary care services. VSO's in City and Hackney will be a key part of community wraparound support people will receive.

Community Dementia Service

A neighbourhood based dementia service will offer continuity of care for patients diagnosed with dementia, from initial assessment and diagnosis through to end of life provision. People with Dementia will benefit from community based services which offers timely diagnosis where residents and their carers receive the right level of care and support at the right time.

8. Our priorities 4: Personalisation and co-production

We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services.

Why it matters

8.1. Involving service users in the development of local plans and services ensures that we are addressing need and using the experiences of service users to improve the quality of support provided. Listening to 'experts by experience' is also critical if we are to design and deliver services that work for people and as part of an integrated care system.

8.2. Co-production is also critical to the development of the neighbourhood model in City and Hackney (see priority 3). This model depends on partners working collaboratively to organise care around the needs and assets of individuals in a way that is service user led.

8.3. A person centred approach will be taken to address people's mental wellbeing. Service users will be involved in decisions concerning their care and recovery and will have choice and control over the support they receive. Care and recovery planning will be personalised, considering people's assets with a focus on their goals and aspirations.

'Shaping the services you use is empowering. It's refreshing to know they want to hear from people using services.'

It is:

'A stronger voice in the community with the support of peers'

'A constructive way of getting things done and being listened to'

"Service user involvement can improve routines, confidence and raise self-esteem and self-awareness."

Feedback from Mental Health Voice members (MH service user involvement project in City & Hackney)

What we will do

8.4. We will continue to pilot and develop the use of personal health budgets in City and Hackney, working with service users to ensure they have greater choice and more control over their care. We will develop our culture, practices and networks to develop the principles and practice of co-production. We will create multi-disciplinary 'teams around the person' as we develop the neighbourhood model across City and Hackney.

KEY ACTIVITIES	WE WILL …. (See Appendix 2 Action Plan for detailed targets)
Putting service users at the centre of their care	✓ Embed service user led care planning and setting of recovery goals in our culture and practice ✓ Expand the use of Personal Health Budgets in City and Hackney, and support service users to make their own decisions about their care ✓ Continue to develop the use of Direct Payments for adult social care
Involvement of families and carers	✓ Implement our Carers Strategies, recognising need and improving support ✓ Involvement of carers of people with dementia as much as they would like to be involved.
Personalised support	✓ Develop online therapies and digital support ✓ Build 'teams around the person' in neighbourhoods (see Priority 3) to help people to address their goals and aspirations ✓ Offer a choice of services to support people's mental wellbeing and actively signpost service users to the services available
Co-productive practice	✓ Implement the *City and Hackney Co-Production Charter* for mental health ✓ Co-productive approaches to developing and monitoring services (e.g. design of Personal Health Budget agreements) ✓ Commission service user involvement opportunities to make sure experts by experience are involved in the design, commissioning and monitoring of services

CASE STUDIES – SOME EXAMPLES of our approach to PERSONALISATION AND COPRODUCTION

Piloting the use of Personal Health Budgets …

A personal health budget is an amount of money to support the healthcare and wellbeing needs of the individual and to give them more choice and control over how it is spent. The use of Personal Health Budgets for people with SMIs will be piloted by the East London NHS Foundation Trust (ELFT) in 2019-20, with a focus on people leaving specialist mental health services. In 2020-21 we hope to bring together Personal Health Budgets and social care direct payments to increase flexibility to build care and support packages around the needs and goals of individuals. We are also interested in expanding the use of personal budgets to people receiving 'step up' support in neighbourhoods. We are looking at how we best involve service users in developing this offer, and the role of the Mental Health Network.

A charter for co-production

Partners have committed to the first-ever *Co-Production Charter for Health and Social Care in Hackney and the City*. The principles include involving people from start to finish in service design and valuing them as equal partners. The charter requires people co-producing services to work together with mutual trust and response, and to share information with the wider community. The Integrated Care System is implementing co-production principles, with public representatives on the boards of all the four workstreams. Service users are represented on the Mental Health Coordinating Committee and have been partners in developing this strategy.

Reviewing care & recovery planning

City & Hackney CCG asked a team of service users to review the care & recovery planning process in City & Hackney and compare existing care and recovery plans from across services. The aim of the project was to determine whether this is a helpful process and what needs to be in place to make sure the process is effective for the individual and person centred. Some key observations from the group were that people need to involved in the process, plans need to be aspiration and goal orientated, people need to have access to their plans and plans should be monitored and reviewed. The feedback will be used to embed service user led care planning and setting of recovery goals in our culture and practice.

9. Our priorities 5: Recovery

Why it matters

We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks

9.1. Above all, a recovery approach is about recognising the strengths and assets of people affected by mental health problems, their families, their support networks and the community – and tapping into these to support people to live meaningful and fulfilled lives, regardless of diagnosis or mental health status. It is about encouraging people with mental health problems to have positive aspirations and ambitions for themselves, and supporting them to achieve them.

9.2. The Recovery approach addresses the needs of the whole person and ensures that those with complex needs do not have problems addressed in isolation.

9.3. It is also about addressing the barriers to social inclusion. Work or other meaningful activity, housing, relationships and social networks matter as much to people with mental health problems as they do for everyone else. Part of this is ensuring that service users understand their rights and receive support to ensure they receive the benefits which they are entitled to.

Recovery means enabling people to the live the lives they want with or without the symptoms of mental health problems.

Centre for Mental Health

9.4. Employment rates are still lower for people with SMIs, than for those with any other health condition. Rethink estimates that 43% of all people with mental health problems are in employment, compared to 74% of the general population. Just under 4% of working age adults in City and Hackney on the Care Programme Approach (CPA) are in paid employment – and 6.5% of those with high needs mental health conditions.

9.5. One in five adults in England in a Shelter survey (2017) said that a housing issue had negatively impacted on their mental health in the last five years, with housing affordability the most frequently cited issue. Lack of appropriate housing is a cause of delays in discharging people from hospitals and other specialist care services, which can hold back recovery and is costly for our health and social care systems.

What we will

9.6. We will work with service users to identify their goals and aspirations and help them to realise them, working with a wide range of partners – in the public, private and voluntary and community sectors - on issues like access to appropriate housing, employability, leisure

KEY ACTIVITIES	WE WILL …. (See Appendix 2 Action Plan for detailed targets)
Access to housing	✓ Review and, where appropriate, redesign housing related support and mental health accommodation pathways ✓ Develop pathways out of homelessness that can work with complex needs by using a person-centred, trauma informed and recovery focused approach ✓ Pilot the Housing First approach
Employability and meaningful activity	✓ Secure funding from NHS England so people in specialist mental health services can access supported employment in City and Hackney businesses ✓ Develop and strengthen the City and Hackney Mental Health Supported Employment Network, establishing outcome measures and monitoring impact
Friendships and networks	✓ Focus on social wellbeing with a focus on loneliness and social isolation ✓ Encourage, support and engage with service user networks (including networks working with specific client groups e.g. autism experts by experience) ✓ Involve the voluntary and community sector as a key partner in providing integrated mental health care

CASE STUDIES – SOME EXAMPLES of our approach to RECOVERY

Pioneering employment support …

The City Corporation and LB Hackney are partners in the Central London Works initiative. This is a £51 million initiative which replaces the national employment support programmes in London (i.e. the Work Programme), and will support up to 21,000 residents across 12 Central London boroughs to find work and manage their health condition. Central London Works has a strong focus on mental health issues.

City and Hackney is also developing its delivery of Individual Placement and Support (IPS) in preparation for a further investment of NHS funding to support this approach locally. IPS has a proven track record of supporting people with severe mental health difficulties into employment, with a combination of rapid job search, placement in paid employment and in-work support for both employee and employer.

Students in self-care and wellbeing …

The Recovery College in the LB Hackney provides courses to empower people to become experts in their own self-care and wellbeing. Students are given tools to manage their mental health and to help families, friends, carers, professionals and the public to better understand their conditions and support their recovery journey. It is a self-referral service, based on an enrolment form. To make the college as accessible as possible a 'buddy system' is available to support students.

Accommodation pathways …

The LB Hackney is recommissioning its Mental Health Accommodation Pathway. It will improve support for people with a high level of complex need (including piloting a Housing First approach). Residential services will be provided for people with severe mental illness and co-morbidity. Following a deep dive review of Health and Homelessness the City Corporation will develop the role of specialist mental health practitioners to provide therapeutic intervention, referral and guidance to outreach practitioners.

10. Four building blocks

10.1 The delivery of our five strategic priorities will be supported by four key building blocks.

WORKFORCE: *We will develop our workforces, and support for carers, peer mentors and volunteers*

To support integrated healthcare we will both expand mental health skills amongst a wider workforce and expand the skills of mental health staff to deal with wider determinates such as physical health substance misuse & homelessness. This involves training staff in primary care, schools and community organisations to understand mental health problems, treat people with dignity and respect and sign-post when appropriate. We will also improve support for our carers and continue work with the voluntary and community sector to facilitate the work of peer networks, community champions, befriending, mentoring and volunteering.

For example, we will:

- ✓ Train GPs and other primary care staff as we roll out of the neighbourhood model
- ✓ Develop mental health first aid (e.g. for schools and businesses)
- ✓ Implement ambitious Carers strategies and involve carers networks and forums
- ✓ Train more Peer Support workers and mentors

DATA AND DIGITAL: *Share data, building a shared evidence-base and develop digital options*

We will respond to the national call for a data and transparency revolution that brings together clinical and social data, with better linkage across the NHS, local authorities, education and other sectors. We will develop the pivotal role of new technologies in driving changes in mental health services.

For example, we will:

- ✓ Explore and develop data sharing protocols and practices and exchange information through our integrated care structures that support integrated pathways
- ✓ Develop on-line support to improve personalisation and autonomy in the delivery of care. We are piloting new uses for online therapies to support a wider access
- ✓ Continue to develop shared care plans that support virtual integrated teams around the patient

ENGAGEMENT: *Listen and learn by working with experts by experience, practitioners and partners*

We have developed this strategy with 'experts by experience' as part of an Integrated Care System, and look forward to working with them at every stage of its implementation. People with direct and indirect experience of mental health problems and those close to them have unique insights into their conditions, the experience of seeking and accessing help and the delivery of services. This is a vital resource for system and service improvement.

For example, we will:

EVIDENCE-BASED POLICY: *Be guided by research and best practice, and monitor the impact of what we do*

We note that the NHS Long-Term Plan highlights the importance of 'further progress on care quality and outcomes' and ensuring that taxpayer investment is used for 'maximum effect, both require an evidence-based approach'. We will ensure we invest in services that deliver outcomes and offer value for money. This strategy will be supported by detailed action planning and the specification of performance indicators.

For example, we will

- ✓ Continue to develop best commissioning practice

✓ Continue to ensure service users have an effective voice on the Mental Health Coordinating Committee ✓ Work with the voluntary and community sector to support service user networks ✓ Commit to the City and Hackney Co-Production Statement for mental health ✓ Continue to develop networks working with specific client groups e.g. young black men, autism etc.	✓ Undertake deep dives on key strategic issues to inform policy and practice ✓ Ensure our politicians and senior leaders are briefed on research and best practice findings.

11 Development, oversight and accountability

11.1 This strategy is supported by an action plan with SMART performance indicators (see table below)The Action Plan will be overseen and managed by a Joint Mental Health Team, reporting to the Mental Health Coordinating Committee (MHCC) of senior officers, partner representatives and service users. Each target will be assigned an MHCC lead. MHCC service user representatives will provide service user oversight. . The Action Plan also aligns each target to a Workstream and progress against the targets will be reported to the relevant Workstream. Accountability for achieving the target ultimately will rest with the relevant Workstream.

11.2 Progress will also be reported to the City and Hackney Health and Wellbeing Boards, at least annually, and to other key committees, including the City and Hackney Adult Safeguarding Board. A short and accessible annual progress report will be produced and published on our websites, as well as disseminated through our service user networks, with opportunities to feed back.

11.3 Councillors serving as Mental Health Champions will provide a voice for the mental health strategy and ensure proper scrutiny within the City Corporation and LB Hackney. We expect that partners will incorporate relevant priorities and outcomes from this strategy in their own work and business planning.

11.4 The environment is changing all the time, with new opportunities and challenges emerging, and we are committed to an evidence-based approach that incorporates new data and research findings, learns from experience and through engagement, and adapts to new circumstances. The Mental Health Coordinating Committee will therefore oversee an annual review and of the strategy, alongside progress reporting. This will be informed by service user evaluations and reports.

Appendix 1: City and Hackney Needs Analysis

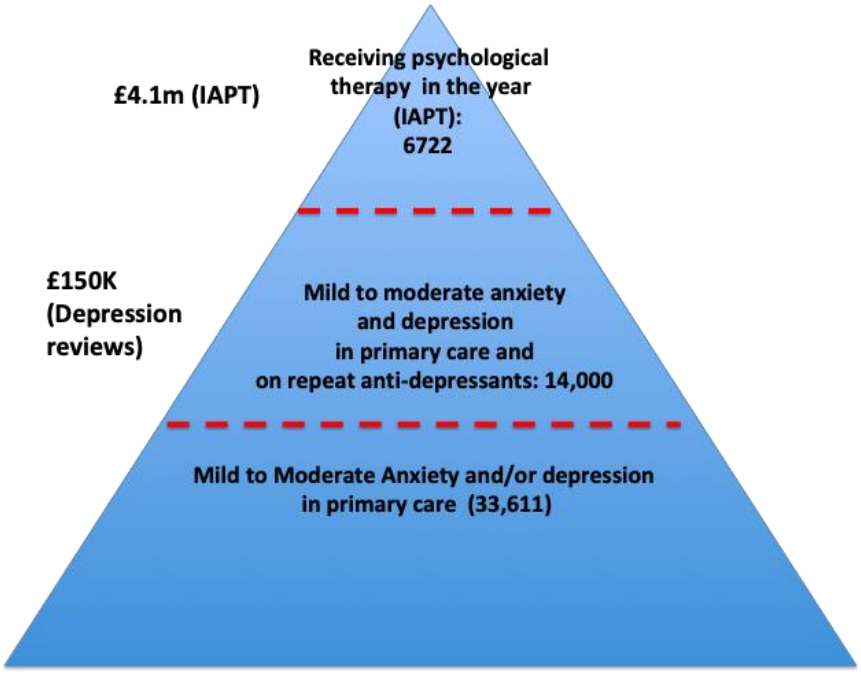
Population: Overview

Overall, City and Hackney has a relatively young, growing and ethnically diverse population. There are significant differences in demographics and in levels of affluence and deprivation across the area, and contrasts between Hackney and the City of London. For example, the City of London has an aging residential population, and an exceptionally large working population that is not resident in the Square Mile. There are significantly higher levels of deprivation in Hackney, and there is greater ethnic diversity.

Across City and Hackney, there is a relatively large cohort of people with serious mental health problems compared to other local areas, and high numbers of A&E, ambulance and 111 frequent attenders.

Adults with common mental health disorders. It is estimated that over 33,000 people across City and Hackney are experiencing depression and anxiety disorders at any one time (NHSE prevalence rate for CH) and that 14,000 are on repeat prescriptions for antidepressants (CEG 2019-20 depression register on EMIS). 20% of these residents accessed 'talking therapies' through the NHS's Improving Access to Psychological Therapies (IAPT) programme in the 12 month period from April 2018 to April 2019 (NHS Digital) The diagram below shows the pyramid of service usage with some indicative CCG spend figures (CCG Finance Dept.).

Figure 1: Common Mental Health Problems - Prevalence and NHS Spend



Of those accessing IAPT treatments some groups are under-represented. Older people are under-represented. People over the age of 65 make up 7.4% of the population (LBH July 2018) however IAPT access rates are only 4%. Men are also under-represented in access rates. Only 32% of those accessing IAPT are male. Young men are under-represented making up just 3.3% of the IAPT access rate, whilst they make up 5.7% of the population. Young Black Men are very strongly under-represented making up just 0.4% of the IAPT access rate (HUH Talk Changes service data). Based on population prevalence the figure should be 1.4% (3.5 times the actual figure.)

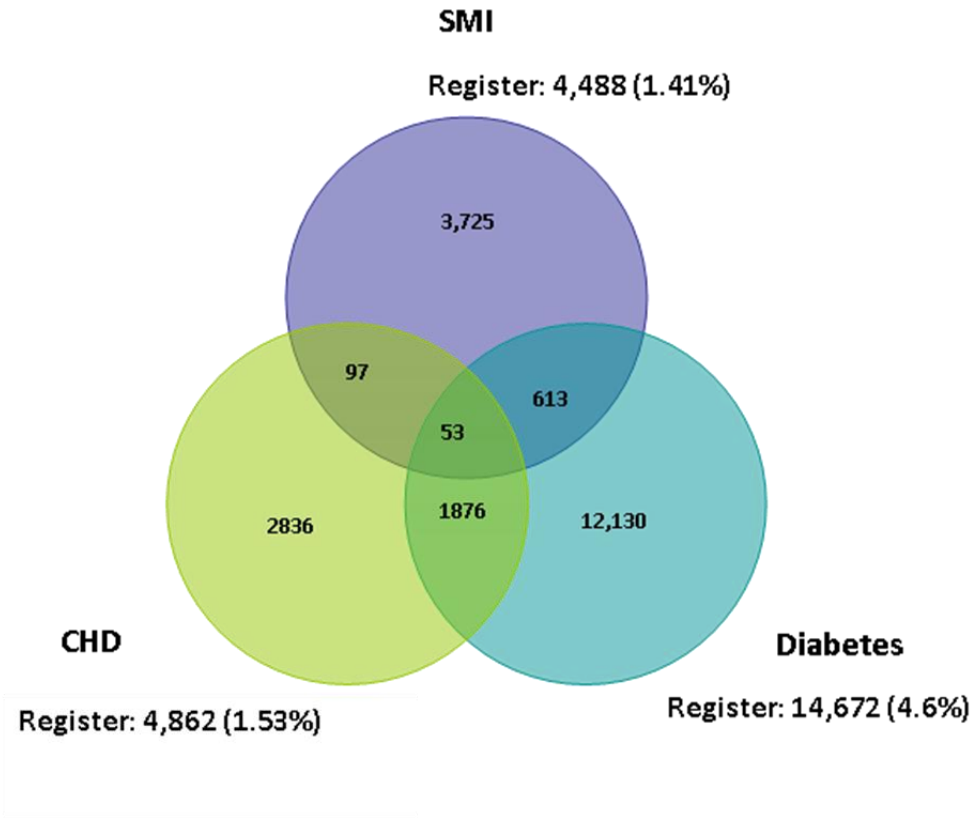
Adults with severe and enduring mental ill health

Severe and enduring mental illnesses (SMIs) include bipolar disorder, schizophrenia (and other psychosis) and personality disorders and severe trauma. SMIs also include more extreme manifestations of depression, anxiety and other common disorders.

City and Hackney has a high prevalence of psychotic and bipolar disorders, with the fifth highest rate in England, and over 4,635 people on the Serious Mental Illness (SMI) Register (CEG 2018-19). About three quarters of this group will be managing their condition with the support of GP and other primary care services, often with some voluntary and community sector involvement. However, nearly half of this group (2,200) engaged with secondary mental health services in City and Hackney at some point over a 12 month period (ELFT informatics dept.)

This group has far poorer physical health than the general population. Smoking rates are 36% and obesity is 50% higher, and life expectancy is between 8 and 18 years lower. Co-morbidity with long term conditions is far higher than in the general population. The figure below shows that 17% of those on the SMI register (763) have either diabetes or CHD (CEG data from EMIS, 2018-19).

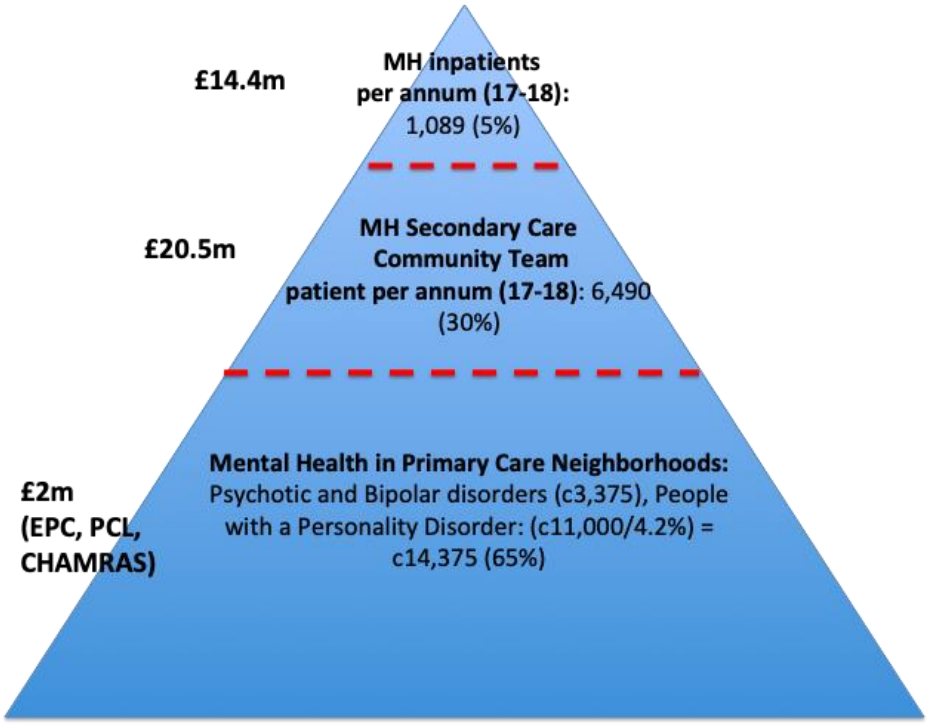
Figure 2: SMI and LTC co-morbidity



There are 1,368 people over 18 diagnosed with a personality disorder in City and Hackney (CEG June 2019 data based on EMIS). However, the number diagnosed is likely to be much lower than the prevalence rate. Prevalence estimates for the UK (British Journal of Psychiatry Vol. 188, May 2006) as a whole are 4.2% population we estimate that there are about 11,000 adults in City and Hackney with a personality disorder, such as borderline personality disorder and antisocial personality disorder (PD). People with PD may have other problems in their lives, such as alcohol and drug misuse, and will overlap with the 'complex need' group (see below).

6,490 people in City and Hackney with severe and enduring mental health problems entered secondary care services in 2017-18 (ELFT data), of which 1,089 were inpatients on the acute wards or Psychiatric Intensive Care Unit (PICU). Service use by people with severe and enduring mental health problems is captured in the diagram below.

Figure 3: Severe and Enduring Mental Health Problems - NHS Spend and Prevalence



It is assumed that most people with a personality disorder will be within the primary care setting. We have not included people with severe and enduring anxiety and depression in primary care within this data set, but this is also a significant number.

People with SMI often have other challenges in their lives, including lack of employment, financial problems, issues with benefits and housing problems.

Employment rates are lower for people with mental health problems, than for any health condition. Rethink estimates that only 43% of all people with mental health problems are in employment, compared to 74% of the general population. Only 8% of people with schizophrenia are in work. Most people with mental health problems say that they want employment. People with SMIs are also over-represented in the homeless population (see below), while others may find themselves in insecure or inappropriate accommodation.

Complex needs and undiagnosed mental health problems

A national report estimates that there are around 58,000 people across England experiencing severe and multiple disadvantage involving substance misuse, homelessness and/or contact with the criminal justice system. Over half (55%) had a diagnosed mental health problem and nearly all (92%) had a self-reported mental health issue. This group can find it difficult to get

the holistic help they need to address their needs, and may be 'bounced between' services - e.g. mental health and substance misuse services.

Drug and alcohol misuse. UK studies suggest that the prevalence of co-existing mental health and substance misuse problems in mental services is between 32% and 46%. While rates have been recorded at 75% in drug services and 86% in alcohol services. Furthermore, a history of alcohol or drug use is also recorded in 54% of all suicides. In City and Hackney, 386 people who started drug and alcohol treatment in 2017-18 (over 40%) had a mental health treatment need. Over a third (37%) of them were receiving no treatment at all, with 20% engaging in specialist services, and 42% receiving treatment from their GP. Women's substance misuse issues are often particularly complex and linked to a variety of issues including childcare, maternity, prostitution, physical and sexual abuse, stigmatisation, as well as mental health. Research shows that nearly half of female dual diagnosis service users have experienced sexual abuse in their lives.

Homelessness. 80% of homeless people[1] in England have a mental health problem, with 45% diagnosed, according to the Mental Health Foundation. In Hackney in 2017-18, 58 of 118 rough sleepers who were assessed (49%) had mental health needs; the equivalent figure for the City of London was 151 of 265 (57%). 58% in Hackney and 47% in the City of London had alcohol treatment needs. The respective figures for drug treatment need were 49% and 51%. Only 15% of the street homeless population across City and Hackney had no identified alcohol, drug or mental health needs.

Crime and offending. HM Chief Inspector of Prisons Annual Report 2017-18 concluded that 79% of women and 71% of men in prison said they had mental health problems. The majority of prisoners who are drug dependent have a least two mental health problems. A significant proportion of police time and resource is spent dealing with mental health related problems, including the detention of people in crisis for assessment under s. 136 of the Mental Health Act.

Mental health and physical health comorbidity. Mental health problems may be undiagnosed and untreated where people present to health professionals with unexplained physical symptoms. In City and Hackney there are currently 272 people who have attended hospital A&E services ten times a year or more without a clear physical causation, over 3,000 A&E attendances. The pressure on A&E services could be alleviated and outcomes improved if these frequent attenders were receiving appropriate psychological, emotional or practical support. Additionally there are 15,169 patients in City and Hackney who have diabetes, of which 2,471 (18%) have uncontrolled diabetes as they are unable to manage their long term condition. This cohort may also benefit from appropriate psychological emotional or practical support.

[1] 'Homeless People' defined as people temporary accommodation, people in accommodation services and people sleeping rough.

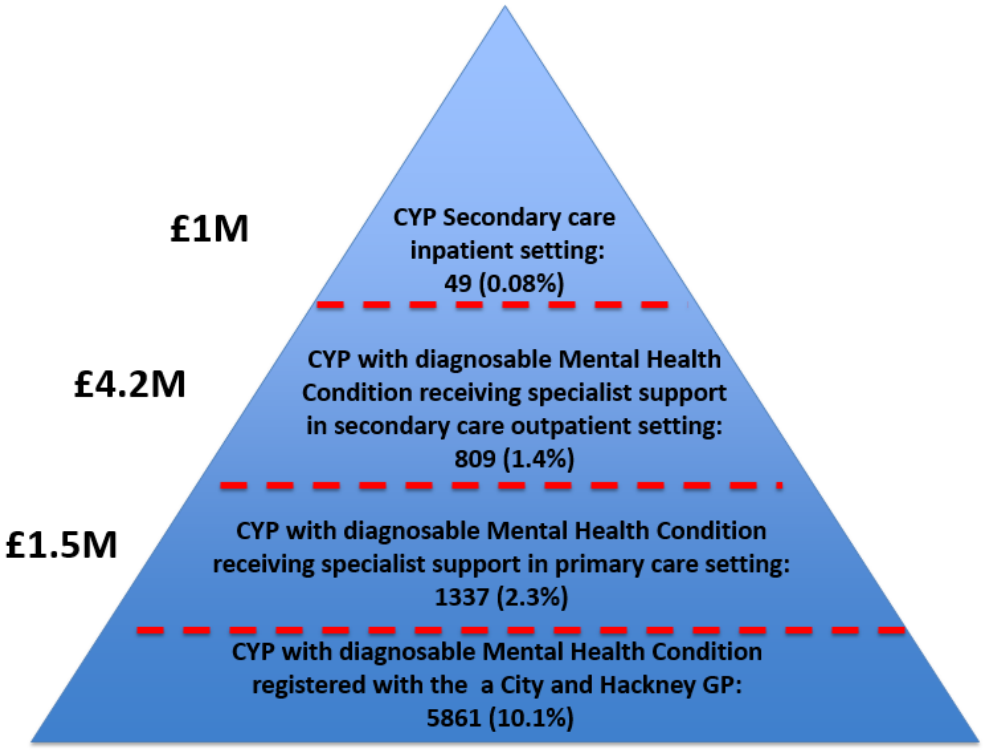
Children and young people's mental health

City and Hackney has a relatively young population that has grown significantly in recent years, and will continue to grow. This is an ethically and culturally diverse population, with significant variations in levels of affluence and deprivation.

Compared to similar areas of London, Hackney has significantly higher numbers of children and young people with Special Education Needs - including more with Social, Emotional and Mental Health Needs - more looked after children, more in Pupil Referral Units and more 16-18 year olds who are not in education, training and employment. While the number of vulnerable children and young people is relatively low in the City of London, this includes some with high risk of emotional and mental health problems - for example, looked after children in the City of London are generally unaccompanied asylum-seeking children.

Across City and Hackney in 2017-18 49 children and young people required inpatient care, over 2,000 received specialist support in the community, and nearly 6,000 were treated for a diagnosable mental health problem by their GP (ELFT, HUH data).

Figure 4: CAMHS Prevalence and NHS Spend



Dementia

Dementia is one of the main causes of disability in later life. It is characterised by progressive memory loss, behavioural and personality changes, impaired reasoning and ability to care for oneself. In the later stages, people become increasingly frail, may have difficulty eating and

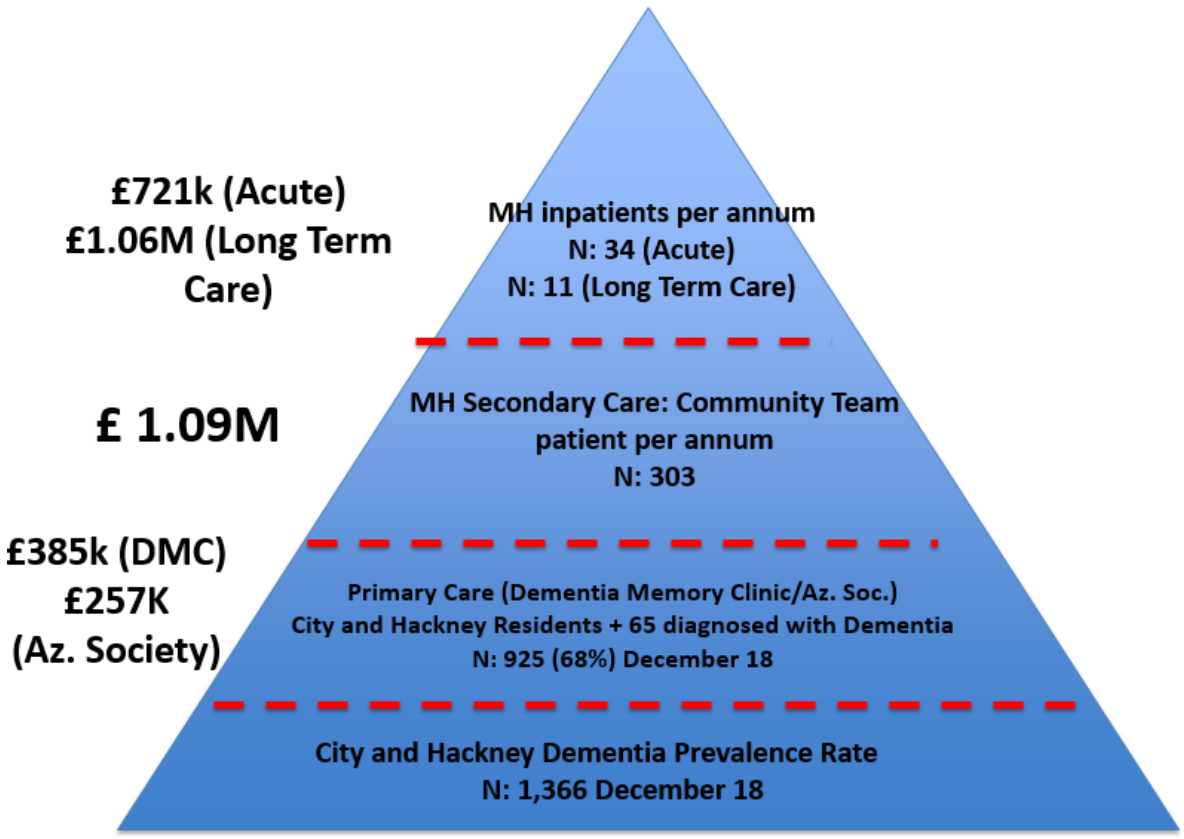
swallowing, experience incontinence and lose communication skills, including powers of speech, and become increasingly dependent on others. This also impacts the emotional wellbeing and mental health of carers.

It is estimated that approximately 1,366 residents in City and Hackney have dementia (NHSE Prevalence Figure for City and Hackney). Around half of those affected have their condition recorded by their GP. 40 people Hackney and City residents *under* the age of 65 have dementia recorded by their GP. These residents are almost all aged 50-64.

Assuming the prevalence of dementia remains the same, the number of people living with dementia in Hackney is expected to increase by one third between 2015 and 2025, from 1,200 to 1,700. The number of people with dementia in the City of London is expected to more than double in this period, from 90 to 190.

Hackney has high rates of dementia detection, compared to both London and England. The diagnosis rate for January 2018 was 71.2% again a target of 66.7%.

Figure 5: Dementia Prevalence and NHS Spend



Appendix 2: Mental Health Joint Strategy Draft Action Plan 2019-23

JOINT MENTAL HEALTH STRATEGY: DRAFT ACTION PLAN 2019 - 23					
PRIORITY 1: PREVENTION					
KEY ACTIVITIES	**WE WILL ….**	**WORKSTREAM GOVERNANCE**	**TARGETS**	**DEADLINE**	**MHCC LEAD(S)**
Prevention	Work across service departments to promote their role in mental health and to develop this, from frontline professionals (e.g. housing officers, registrars) to strategic leads (e.g. within planning, transport, leisure and culture)	Prevention	1) MHFA offered to all front line workers in C&H 2) Embed mental health early identification and support to workplace mental health within the council.	Achieved end of year 1 and then monitored thereafter	LBH

	Work to reduce stigma and promote positive mental wellbeing		1) Deliver joint communications campaigns to the general population, as well as targeted campaigns with groups at the highest risk of poor mental health		LBH/CCG communications
	Join the Prevention Concordat for Better Mental Health		1) Joining the MH Concordat by august 2019 2) Training of Mental Health Member champion	Achieved end of year 1 and then monitored thereafter	LBH/CoL
	Develop a dementia friendly community across City and Hackney		1. Expand the membership of Dementia Friendly Hackney	Q3 19/20	LBH/CoL
			2. Coordinate a programme of activates for the Hackney Dementia Festival		
			3. Launch the Hackney User Involvement group		

			4. Engage with local youth organisations, including Scouts and Guides, to make them aware of dementia-friendly resources		
			5. Plan the delivery of a 'Dementia-friendly Churches' conference		
			6. Organise the first Dementia Friendly Hackney housing group meeting and a programme of activities for housing with care schemes		
	Improve the assessment of physical health for people with mental health problems and access to supportive interventions		1) Reduce isolation, and increase quality of life	Q4 19/20	CH CCG
			2) Combat a sedentary lifestyle, tackle obesity and enhance improvement in mental and physical wellbeing		

	like Core Sports		3) Reducing the reliance on other medical and emergency services acting as a preventative measure against relapse or as a coping mechanism to aid and enhance recovery.		
			4) Improve experience of care and support		
	Improve the identification of loneliness through a biopsychosocial approach to neighbourhood mental health assessments and improve supportive interventions in the VCSE sector. Improve the range of		TBC	TBC	CH CCG

	supportive interventions				
	Think Family Approach: Provide extra support to children and unborn children in families where the adults have mental health or substance abuse issues.		Audit and evaluate the use of the 'Think Family' approach to meet the needs of children living in households with adults with additional needs.	A multi-agency audit in January 2019, carried out by the Safeguarding Children Board highlighted that the Think Family approach was having a positive impact by ensuring mother's needs and vulnerability were considered in planning and intervention.	CoL

	Think Family Approach: Identify and provide additional mental health support for our most vulnerable children and young people with social care needs and children in care		Mental Health Needs Assessment; 0-5 Needs Assessment; 5-19 Needs Assessment; Substance Misuse Needs Assessment	Mental Health Needs Assessment; 0-5 Needs Assessment; Substance Misuse Needs Assessment; 5-19 Needs Assessment are currently being updated.	CoL
	Health Visiting: Deliver additional mental health support to vulnerable new and expectant mothers.		Commission an enhanced health visiting service with a specification to assess and identify maternal mental health concerns and offer subsequent support.	The new health visitor service (provided by the Homerton Hospital) is commissioned by the London Borough of Hackney, the contract started on 1st July 2016.	CoL

	Health Visiting: Research and assess the need for MH services and support for victims and perpetrators of domestic violence and abuse, and their children		Include questions on MH in assessments of victims and perpetrators of domestic abuse and their children, and refer them on to appropriate care	DV specialist social worker in post	
			Explore options to offer a non-clinical alternative to CAMHS as first step support for children and young people affected by domestic violence and abuse		CoL
	Open Spaces		TBC	TBC	CoL

Early Years, Families and Young People	Develop perinatal support	Children and Maternity	Expand support in line with NHSE target	Q1 2019-20	CH CCG /CoL
	Develop designated senior mental health teams in schools and Mental Health Support Teams for early intervention and ongoing help at school		1) 100% of State maintained Schools with WAMHS by 2020 2) 50% of state maintained schools with MHSTs by 2020 3) 50% of Faith Schools completed mapping by 2020	Q4 2020-21	CH CCG /CoL
	Develop our offer to children with Special Educational Needs and Disabilities		1) Fully evaluate and implement recommendations of Neurodevelopmental Pathways by April 2020 2) Set priorities for on-going mapping for other disabilities and SEND pathways	Q4 2020-21	CH CCG /CoL

	Implement the third phase of our Local Transformation Plan for Children and Young People's Mental Health Services (CAMHS)		All objectives for Phase 3 delivered by April 2020 / Part B by April 2021	Q4 2020-21	CH CCG
Workplace	Support businesses and employers to encourage wellbeing among their workforce and to tackle Mental Health Related Stigma, including signposting to	Prevention	1) Work with Business Healthy and the "this is me" campaign in the City 2) Encourage businesses to compete the Healthy Workplace Award 3) improve workplace mental health in Hackney Council and appropriately signpost staff	Achieved end of year 1 and then monitored thereafter	CoL

	local support services		number of employers engaging with business healthy events and communications/ activities with a mental health focus (70%) ; positive feedback received from attendees of Business Healthy Events		
	Support NHS workforce to access mental health wellbeing support		All staff to have access mental health wellbeing support	Q3 2020-21	CH CCG
	Support local campaigns such as "Release the Pressure" and "This is Me"		1) support national campaigns such as World Mental Health Day, Mental Health awareness week 2) develop specific local campaigns where appropriate e.g. Release the Pressure Campaign	Achieved end of year 1 and then monitored thereafter	LBH/CoL
Mental health crisis and suicide prevention	Develop and implement the City and	Unplanned Care	1) up to date suicide audits for City and Hackney	On-going annual target	LBH/CoL

	Hackney suicide prevention action plans		2) develop an action plan for both the City and for Hackney Suicide Prevention Multi-agency groups 3) 10% reduction in suicides in City and Hackney.		
			Hackney: 2012-2014 7.5 per 100,000 population		
	Continue to provide Samaritans-led Suicide Prevention Awareness sessions to representative of the City's business community		1) continue partnership between the City of London Corporation and the Samaritans to deliver suicide prevention training to City businesses	ongoing 3/4 sessions a year	CoL
	Strengthen our crisis pathway with more accessible services that reach beyond statutory		Pilot high intensity/frequent attender service based on use not diagnosis	Q4 2019-20	CH CCG

	mental health services				
Awareness and Information	Improving online information and use of digital channels and social media.	Prevention	Growth in online therapy by 50% to 1,500 IAPT and non IAPT	Q4 2020-21	CH CCG
	Train school staff in MHFA and suicide prevention		At least two staff members in each school is trained	Ongoing once every three years due to staff turnover	LBH/CoL
	Develop communications campaigns to support mental wellbeing		Delivery of a Five to thrive website/communications with up to date and relevant content of resources, activities and courses available in the borough which is maintained to ensure on-going use	Q1 2020-21	CH CCG
Get support to people quicker	Develop open access and low threshold services (see	Unplanned Care	Expand use of crisis café and SUN project by 30%	Q4 2020-21	CH CCG

	priority 2 – Access)				
	Pilot and implement the Every contact counts campaign		Frontline LA staff trained in quick intervention	Feb-20	LBH
	Ensuring everyone in the City and Hackney with dementia has access to the right level of care at the right time		Launch Community Dementia service	Q2 2019-20	CH CCG

PRIORITY 2: ACCESS					
KEY ACTIVITIES	**WE WILL ….**	**WORKSTREAM GIVERNANCE**	**TARGETS**	**DEADLINE**	**MHCC LEAD**
Open Access	Introduce whole school approaches to mental health and wellbeing through CAMHS Transformation Plan	Children and Maternity	1) 100% of State maintained Schools with WAMHS by 2020 2) 50% of state maintained schools with MHSTs by 2020 3) 50% of Faith Schools completed mapping by 2020	Q4 2020-21	CH CCG/CoL
	Develop our no wrong door approach to CAMHS services	Children and Maternity	Develop single point of entry and patient journey navigation system by April 2020. Delivered by the IT and Tech WS in the CAMHS Alliance	Q4 2020-21	CH CCG
	Develop open access services	Planned Care	Expand use of crisis café, SUN project and Recovery college use by 30%	Q4 2020-21	ELFT

	Improve timely access to good quality crisis services in line with London MH Compact	Unplanned Care	Refurbished HBPoS/136 suite with additional staffing. Compliance with London Compact targets for timely access.	Q4 2019-20	ELFT
	Improve access for people in crisis through mental health street triage	Unplanned Care	Create referral pathway between street triage and rough sleeping healthcare, decreased rate of incarceration under s136	Q4 2019-20	CH CCG /CoL
Physical health and mental health	Develop assessment, referral and integrated care pathways to diagnose and address the mental health needs of people presenting with physical illness	Prevention	50% increase in LTC psychological support access rate from 2018-19 baseline. 20% of the 2,471 with poor control diabetes will access IAPT services.	Q4 2020-21	CH CCG

	Target action to reduce numbers of frequent users of A&E, ambulance and mental health services by addressing undiagnosed mental health need	Unplanned Care	50% reduction p.a. from baseline of 400 frequent attenders 10X + p.a.	Q4 2020-21	CH CCG
	Build on our programme of physical health reviews for people with SMI by increasing their frequency and strengthening the support offer for those at risk of physical illness	Prevention	70%+ of SMI population receive a physical healthcheck	On-going annual target	CH CCG

	Pilot sport and healthy eating programmes for people with SMIs	Prevention	150 people with SMI referred into pilot	Q4 2019-20	CH CCG
Dual diagnosis and complex need	Invest in Multiple Needs Service for those with multiple and complex needs	Planned Care	Complete and evaluate complex needs pilot and embed best practice in recurrently funded services	Q2 2020-21	CH CCG
	Equip and develop our workforces to work collaboratively and flexibly across service and professional boundaries	All Workstreams	Expand MH training to cover HCAs, practice nurse & social prescribers	Q4 2020-21	CH CCG

	Jointly develop a new substance misuse contract that better integrates substance misuse and mental health services including: psychiatric liaison; a seamless pathway between MH and substance misuse services and ensuring that people with substance misuse problems have access to support for their mental health needs.	Unplanned Care	Create a new integrated health and social care substance misuse contract which embeds services in Psychiatric Liaison team and offer access to therapy with specialist support.	Q2 2019-20	LBH/CH CCG

	Improve tailored support for people who are homeless or sleeping rough taking account of chaotic lifestyles and complex need integrated mental health, substance misuse and physical health services	Planned Care	Offer mental health services through Greenhouse practice and satellite in the City	Q4 2019-20	LBH/CoL
	Develop the 'housing first' approach to rough sleeping	Planned Care	Complete housing first 2 year pilot	Q2 2021-22	LBH/CoL
	Work with businesses to improve understanding and address the links between alcohol and	Prevention	1) Programme of work in the City through Business Healthy. 2)Encourage business to complete Healthy workplace charter	Achieved end of year 1 and then monitored thereafter	CoL

	drug misuse and mental health in the workplace				
Addressing diversity	Develop effective pathways and provision for key equalities groups, with a focus on young black boys and men, the LGBTQ community and older adults through links with communities, community champions and community organisations	All Workstreams	Appoint YBM and LGBTQ leads in IAPT services. Implement the City's wellbeing strategy to tackle social isolation and inequalities	Q3 2019	CH CCG/CoL/ELFT

	Monitor equalities in assessing delivery of our strategic priorities and actions and performance of our services and those we commission		1. YBM IAPT access rate increase by 100% .2. Older adult increase in access rate or achieve quality premium. 3. Male access rate increase by 5%	Q4 2019	CH CCG
	Ensure under-represented groups are better represented in the workforce		Monitor workforce diversity for CYP and adult IAPT	Q4 2019	CH CCG/LBH/CoL
	Ensure that services meet the needs of under-represented groups and do not prevent barriers to access		Report identifying underrepresented groups and barriers to access	Q3 2019-20	CH CCG/CoL

PRIORITY 3: NEIGBOURHOODS					
KEY ACTIVITIES	**WE WILL ….**	**WORKSTREAM GIVERNANCE**	**TARGETS**	**DEADLINE**	**MHCC LEAD**
Neighbourhood teams	Develop 'teams around the person' with virtual teams from different organisations formed around the patient - teams will have a designated lead professional but will put the patient at the centre of their care plan	Unplanned Care	Pilot MH care coordinators & virtual teams for complex cases in neighbourhoods	Q4 2019-20	CH CCG

Focal points for care	Develop the roles of navigators, care co-ordinators, social prescribers and coaches in an integrated way to create a 'seamless service' for the service user	Unplanned Care	Pilot MH care coordinators and virtual teams working with complex cases in neighbourhoods	Q4 2019-20	CH CCG/CoL
	Reduce unnecessary secondary care use		Reduction in no. entering secondary care community and inpatient services - 50 a month (city action plan target)	Q4 2020-21	CH CCG
	Ensure everyone diagnosed with dementia has a named navigator from diagnosis to end of life where VSO are a key part of the community		In place by Q2 2019	Q2 2019-20	CH CCG

	wraparound support				
	Develop transition services and pathways in the community, especially for young people falling out of conventional mental health services		18-25 YP 'super- hub' operational	Q3 2019-20	CH CCG
Culture, skills and confidence	Implement recovery and co-production models for neighbourhood mental health provision	Unplanned Care	MH service user engagement in neighbourhoods.	Q4 2020-21	CH CCG

	Continue to improve the care provided in primary care and through community organisations and networks through mental health training and awareness initiatives		MH training delivered to navigators, social prescribers, HCAs	Q4 2020-21	CH CCG/LBH/CoL
Dementia	Create a neighbourhood-based dementia service with continuity of care from diagnosis to death	Unplanned Care	Launch Community Dementia service	Q2 2019-20	CH CCG
	Support and work with community organisations to support people living with dementia,		Launch Community Dementia service	Q2 2019-21	CH CCG

	their carers and families				
PRIORITY 4: PERSONALISATION AND CO-PRODUCTION					
KEY ACTIVITIES	**WE WILL ….**	**WORKSTREAM GIVERNANCE**	**TARGETS**	**DEADLINE**	**MHCC LEAD**
Putting service users at the centre of their care	Embed service user led care planning and setting of recovery goals in our culture and practice	Planned Care	All service users with multiple/complex needs to have service user led recovery care plans	Inpatient Q4 2019-20. Community Teams Q4 2020-21. Neighbourhoods: Q4 2021-22	CH CCG
	Expand the use of Personal Health Budgets in City and Hackney, and empower service users to make their own decisions	Planned Care	180 personal health budgets	Q4 2019-20	CH CCG

	about their care				
	Align mental health personal health and social care budgets within an integrated pathway	All Workstreams	Aligned or integrated budgets	Q2 2020-21	CH CCG/CoL
Involvement of families and carers	Implement the City's Carers Strategies, recognising need and improving support	All Workstreams	Reported increase in quality of life of carers of people with mental health problems in adult social care (Survey of Adult Carers in England -SACE)	Year-on-year improvement and this will be measured using SACE data.	CoL
Personalised support	Continue to use the Open Dialogue approach, involving family, social networks and a	Planned Care	Expand use beyond CRHT	Q4 2019-20	CH CCG

	whole systems approach				
	Develop online therapies and digital support	Planned Care	Growth in online therapy by 50% to 1,500 IAPT and non IAPT	Q4 2020-21	CH CCG
	Build 'teams around the person' in neighbourhoods (see Priority 3)	Unplanned Care	Pilot MH care coordinators and virtual teams working with complex cases in neighbourhoods	Q4 2019-20	CH CCG
Co-production practice	Implement the City and Hackney Co-Production Charter for mental health	All Workstreams	Implement all agreed charter tasks through MH Advocacy project	Q4 2019-20	CH CCG/LBH

	Co-productive approaches to developing and monitoring services (e.g. design of Personal Health agreements)	Planned Care	180 co-produced personal health budgets	Q4 2019-20	CH CCG

PRIORITY 5: RECOVERY					
KEY ACTIVITIES	**WE WILL ….**	**WORKSTREAM GIVERNANCE**	**TARGETS**	**DEADLINE**	**DEADLINE**
Access to housing	Review and, where appropriate, redesign housing related support and mental health accommodation pathways	Planned Care	Recommission a brand new, fit for purpose pathway embodying the principles of recovery, service user autonomy and value for money. City's housing strategy is implemented	Q1 2020-21	LBH/CoL
	Develop pathways out of homelessness that can work with complex needs by using a person-		Offer recovery planning and psychological support Inc. trauma informed at Greenhouse and City satellite, City's homelessness strategy is implemented	Q4 2019-20	CoL/CH CCG

	centred, trauma informed and recovery focused approach				
	Pilot the Housing First approach		20 people supported through Housing First Pilot	Q2 2021-22	LBH/CoL
Employability and meaningful activity	Develop primary care employment support offer in each neighbourhood	Prevention	Access to employment support in primary care for people with mental health problems	Q2 2021-22	CH CCG
	Secure funding from NHS England so people in specialist mental health services can access supported employment in		120 people with SMI supported into employment	Q4 2020-21	CH CCG/CoL

	City and Hackney businesses				
	Develop and strengthen the City and Hackney Mental Health Employment Support Network, establishing outcome measures and monitoring impact		Access to employment support in each neighbourhood for people with mental health problems	Q4 2019-20	LBH/CH CCG
Friendships and networks	Focus on social wellbeing with a focus on loneliness and social isolation	Prevention and Unplanned Care	GP's to assess for social isolation for people with Mental Health problems, implement the City's social wellbeing strategy	Q1 2020-21	CH CCG/CoL

	Encourage, support and engage with service user networks		Access to peer support and social activities for people with Mental Health problems	Q1 2020-21	CH CCG
	Increase the number of referrals to the Social Prescribing service from the Neaman practice and increase the number of activities it refers to.		Numbers of referral increase and a range of activities are available	ongoing	LBH/CoL
	Involve the voluntary and community sector as a key partner in providing integrated mental health care		Voluntary and community sector provision available within the integrated mental health care offer, city's befriending scheme is implemented	Q3 2020-21	CH CCG /CoL

Appendix 3: City and Hackney CAMHS Transformation Plan (Phase 3): Implementation (2019-20)

Executive Summary

Our vision is that by 2020/21 we will have in place a system that meets the mental health needs of every child in City and Hackney. There will be no thresholds and no wrong doors. The system will exist beyond traditional health care settings extending in to schools and the wider community. It will be seamless and child / family centred, continually adapting through local service user empowerment and engagement. It will be optimised to catch mental health issues as early as possible preventing long term mental problems developing or escalating. Every intervention given will be supported by the robust evidence as every service becomes part of the CYP IAPT Programme. In doing so, it will be highly cost effective, making best use of every penny spent.

City and Hackney has a relatively young population which has grown significantly in recent years and is projected to continue to grow. The City of London and London Borough of Hackney are both ethnically diverse and are projected to become increasingly diverse with extreme variances in levels of deprivation across the area. Although children in City and Hackney are reporting relatively good levels of happiness there are a number of underlying issues that make it stand out from similar local authorities in London. Hackney has significantly higher numbers of children in SEMH and Pupil Referral Units. It has higher proportion of children with Special Education Needs (SEN), 16-18 year olds who are not in education, employment or Training (NEET) and looked after children. These children are likely to have increased mental health need when compared to others.

City and Hackney has a relatively high quality and comprehensive provision of CAMHS available to all children and young people in the area. The CCG has historically invested significantly in CAMHS and this investment continues to grow through the CAMHS Alliance and CAMHS Transformation Programmes, both of which are transformational. The CAMHS Transformation Programme is now entering Phase 3. The first phase is now operational with a recurring investment of £526,769 addressing previously identified gaps locally and in alignment with Future in Mind. Phase 2 and 3 represents on overarching whole-system strategy to improve mental health and wellbeing outcome for children and young people through 18 comprehensive workstreams representing additional investment of £1.2M in to children's mental health:

1. Schools, Education, Training and Employment
2. Transitions
3. Crisis and Health Based Places of Safety (HBPoS)
4. Families (previously parenting)
5. Core CAMHS Pathways

6. Communities (previously Reach and Resilience)
7. Youth Offending
8. Eating Disorders
9. Perinatal and Best Start
10. Safeguarding
11. Early Intervention in Psychosis
12. Primary Care
13. Wellbeing and Prevention
14. Physical Health and Wider Determinants
15. Quality and Outcomes
16. Digital and Tech
17. Workforce Development and Sustainability
18. Demand Management and Flow

The table below provides a summary of CAMHS investments increases from 2014/15 baseline. CAMHS transformation represents an increase of £1.7m.

CCG Funded : City and Hackney	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
ELFT: Specialist CAMHS	£3,413,106	£3,467,000	£3,964,502	£3,968,602	£4,211,540	£4,215,752	£4,219,967
ELFT: Perinatal Services	£215,373	£287,793	£288,000	£288,288	£331,068	£331,399	£331,730
HUH: CAMHS Enhanced ASD	£41,000	£42,000	£45,000	£46,817	£47,566	£47,614	£47,661
HUH: First Steps	£1,080,670	£1,070,000	£1,082,000	£1,085,970	£1,103,346	£1,104,449	£1,105,554
HUH/ELFT: CAMHS Disability	£455,508	£451,000	£458,000	£459,854	£460,314	£460,774	£461,235
Well Family Plus	£0	£285,000	£285,000	£285,000	£285,000	£285,000	£285,000
Sub Total (CCG funded)	**£5,205,657**	**£5,602,793**	**£6,122,502**	**£6,134,531**	**£6,438,834**	**£6,444,988**	**£6,451,148**
Reach and Resilience	£0	£82,766	£66,355	£66,355	£66,421	£66,488	£66,554
Developing CYP Outcomes	£0	£52,260	£0	£0	£0	£0	£0
Perinatal	£0	£36,472	£67,568	£67,568	£67,636	£67,703	£67,771
NICU Trauma	£0	£39,105	£36,978	£36,978	£37,015	£37,052	£37,089
ASD Ed Psych	£0	£77,090	£59,141	£59,141	£59,200	£59,259	£59,319
Psych and Paed Liaison	£0	£30,091	£80,548	£80,548	£80,629	£80,709	£80,790
Off-Centre YIAC	£0	£10,205	£39,316	£39,316	£39,355	£39,395	£39,434
Youth Offending	£0	£6,623	£26,491	£26,491	£26,517	£26,544	£26,571
Information Systems	£0	£41,785	£0	£0	£0	£0	£0
Eating Disorder Service	£0	£190,000	£175,000	£150,000	£213,476	£213,848	£213,848
Parenting	£0	£0	£38,000	£168,000	£0	£0	£0
Child to Adult Transition	£0	£0	£38,000	£70,500	£0	£0	£0
Phase 2 Crisis Pathway	£0	£0	£38,000	-	£267,000	£184,000	£117,000
Interfaces with Schools	£0	£0	£88,000	£324,469	£0	£249,000	£500,000
Project & Evaluation Costs	£0	£0	£48,000	£88,361	£0	£255,902	£248,702
Off-Centre Clinical Pilot	£0	£0	£18,350	£0	£0	£0	£0
Waiting List Initiative	£0	£0	£134,000	£0	£0	£164,000	£0
Youth Justice	£0	£0	£48,733	£0	£0	£0	£0
Conduct Disorder Pathway	£0	£0	£27,000	£0	£0	£0	£0
CAMHS Alliance	£0	£352,000	£0	£0	£0	£0	£0
Outcomes Phase 2	£0	£0	£0	£0	£0	£28,000	£0
Digital Interventions	£0	£0	£0	£0	£0	£49,000	£0
Training and Development	£0	£0	£0	£0	£0	£42,000	£42,000
Family Action (Schools)	£0	£458,351	56,250	£0	£0	£0	£0
First Step Access	£0	75,000	£0	£0	£0	£0	£0
Building Reach and Resilience	£0	186,868	£0	£0	£0	£33,000	£0
ASD Pathway Improvement	£0	£0	£0	£0	£67,000	£67,000	£67,000
Primary Care Step Down	£0	£0	£0	£0	£67,000	£90,000	£90,000
Child Bereavement	£0	£0	£0	£0	£0	£0	£0
Children's ASD	£0	£0	£0	£0	£0	£0	£0
CAMHS Transformation	**£0**	**£1,638,616**	**£1,085,730**	**£1,177,727**	**£991,249**	**£1,752,900**	**£1,656,077**
Sub Total CCG	**£5,205,657**	**£7,241,409**	**£7,208,232**	**£7,312,258**	**£7,430,083**	**£8,197,888**	**£8,107,225**
Sub Total LBH: CFS Clinical Services and other CFS	**£1,409,138**	**£1,587,020**	**£1,628,641**	**£1,716,973**	**TBC**	**TBC**	**TBC**

This local increase in investment equates to significant increase in front line clinical staff providing direct interventions

	15/16 Baseline – Pre CAMHS Transformation		16/17 Post transformation plan phase one		17/18 Post transformation plan phase two	
Service	Clinical WTE	Non-Clinical WTE	Clinical WTE	Non-Clinical WTE	Clinical WTE	Non-Clinical WTE
HUH First Steps	17.5	1.5	18	1.5	18	1.5
HUH CAMHS Disability	8.3	1.0	9.9	1.0	11.2	1.2
HUH Children's ASD	0	0	0	0	1.2	0
ELFT Specialist CAMHS	34.7	10.1	36.0	10.1	38.8	10.9
Off-Centre	0	0	0.2	0	0.2	0
Family Action	0	0	0	0	3.4	0.8
LBH: CFS	10.36	0	16.8	0	22.4	0
Total	**70.86**	**12.6**	**80.9**	**12.6**	**95.2**	**14.4**

Increased capacity has allowed us to increase the number of new CYP seen per year and meet increasing demand

	14/15	15/16	16/17	17/18
Referrals	1749	1874	2170	2422 (38% increase)
Referrals Accepted	1644	1553	1733	1842
New Patients Seen	1452	1494	1657	1782 (22% increase)
Contacts	12798	15019	16856	18605

Title of report:	Planned Care Detailed Review
Date of meeting:	10 October 2019
Lead Officer:	Siobhan Harper, Planned Care Workstream Director
Author:	Siobhan Harper, Planned Care Workstream Director
Committee(s):	Clinical Executive Committee – 9 October 2019 CCG Finance and Performance Committee - 14 October 2019 Finance and Performance Committee - 23 October 2019 Patient Participation and Involvement Committee – 14 November 2019
Public / Non-public	Public

Executive Summary:

In line with the agreed reporting cycle, this report is the latest in the twice-yearly detailed review reports into the performance of the Planned Care workstream. It provides a summary of the latest performance, challenges, issues and risks alongside an update on progress on transformation plans and the delivery of the workstream asks.

Highlights include:

- **Elective** activity is under plan. There are issues with inpatient actvity but this is primarily due to some short term waiting list clearance in Barts and a reporting issue with UCLH
- **Outpatients** Attendances are over plan. The independent audit at Homerton Hospital led by Grant Thornton are reviewing counting and coding practice.
- **Learning Disability -** Joint funding implementation of our agreed protocol has been slower than anticipated though a robust plan is in place to ensure we meet our planned milestones.
- **NHS** Constitution standards remain on target though we have some fragility on our Continuing Health Care target and our Learning Disability IAF targets. Again, we have robust processes in place to monitor and ensure delivery.
- Significant improvements in our **early diagnosis of cancer** with a reduction in late presentations (top 10 CCGs in England) and sustained improvement in staging data. We have recently reapplied for Macmillan funding for our GP clinical lead, which we are also seeking to add to with an additional GP clinical leadership role.

Further detail is provided in the attached Appendix – Planned Care Workstream Detailed Review (October 2019)

Recommendations:

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

- To **NOTE** the detail of the Planned Care Detailed Review summarised in this report.

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

- To **NOTE** the detail of the Planned Care Detailed Review summarised in this report.

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

Deliver a shift in resource and focus to prevention to improve the long term health and wellbeing of local people and address health inequalities	☒	Prevention is a key focus. There are a number of initiatives to improve the long-term health and wellbeing of local people and address health inequalities detailed in the report.
Deliver proactive community based care closer to home and outside of institutional settings where appropriate	☒	Delivering community based care close to home and outside of institutional settings where appropriate is the focus of a number of workstream initiatives detailed in the report.
Ensure we maintain financial balance as a system and achieve our financial plans	☒	The Planned Care workstream is proactively working with all partners to deliver financial balance across the system.
Deliver integrated care which meets the physical, mental health and social needs of our diverse communities	☒	Integrated Care is fundamental to the work of the Planned Care workstream and the report includes details of a number of initiatives currently underway.
Empower patients and residents	☒	Patient and resident empowerment is a priority for the Planned Care workstream and it is embedded into the work of the workstream.

Specific implications for City

All workstream activity is delivered across City and Hackney. Any specific issues for City residents or services are detailed in the main report.

Specific implications for Hackney

All workstream activity is delivered across City and Hackney. Any specific issues for Hackney residents or services are detailed in the main report.

Patient and Public Involvement and Impact:

The Planned Care workstream works in line with the principles of the Co-production Charter. Resident Representatives attend all Core Leadership Group (CLG) meetings and regular 'Let's Talk' community engagement sessions are completed.

Following best practice, Patients/residents are also involved in the detailed design and implementation of specific proposals.

Clinical/practitioner input and engagement:

Clinical Leads attend all CLG meetings and the Planned Care Clinical Management Group meets monthly to discuss any relevant issues. Appropriate clinical experts are a key part of the multi-disciplinary teams responsible for the development of specific workstream initiatives.

Equalities implications and impact on priority groups:

Equality and Diversity is a priority for the Planned Care workstream and it is embedded into the work of the workstream. Any specific issues are addressed in the detail of this report.

Safeguarding implications:

Whilst no specific safeguarding issues have been identified in the report the workstream is committed to ensuring that the highest standards are safeguarding are maintained across the partner organisations.

Impact on / Overlap with Existing Services:

The report encompasses joint or overlapping proposals with other Integrated Commissioning workstreams and the Neighbourhood Programme as well as existing service provision that is within the scope of the Planned Care workstream.

Supporting Papers and Evidence:

Planned Care Detailed Review

Sign-off:

Planned Care Workstream SRO: Andrew Carter

Planned Care Workstream
Detailed Review

October 2019

Executive Summary and Key Points

Prospective opportunities – for the coming year

Neighbourhoods Health and Care

Opportunities to go further with alternative models for outpatient care and care for people with long term conditions in line with the LTP and out of hospital services. Some of this may be supported by national funding for the LTP locally.

Offers an opportunity to better manage the longer term needs of people with mental health problems and avoid revolving door contact with secondary care mental health services and improving early intervention prevention. There is potential NHSE funding to support this.

Opportunity to integrate ELFT's primary care facing teams into a single neighbourhood based MH teams capable of assessment, step down, step up and on-going support. Also an opportunity to shift resources from CMHTs and outpatients in neighbourhoods.

Co-Production Opportunities

Through the development of our approach to personalisation we will focus on self-management, ensuring residents are equipped with information to make the best use of their time with services. This will build on the work on navigation and community support led by Prevention and Neighbourhoods.

Digital Opportunities

Linking with NEL and exploring further options through outpatient transformation for both clinical systems and patient access and with the directory of services work locally.

Transformation plans (more detail in later slides)

Continuing Health Care

NEL has some agreed initial proposals regarding scale scope and geography for this review and will begin a programme for NEL at the end of October. City & Hackney will participate and shape the proposals, ensuring that the system based focus (especially on care delivery) will be maintained where it makes sense. We will coordinate a City and Hackney perspective on the future model.

We are reviewing our approach to pooled budgets collectively with our partners whilst maintaining our aims for joint commissioning, joint brokerage and joined up systems regarding direct payments and personal health budgets.

Housing

Our housing first service is about to contracted. We have further plans on working with housing needs colleagues on increasing the understanding of the health needs of homeless people in temporary accommodation.

MH Accommodation & Homelessness

We currently reviewing existing medium and high need mental health accommodation contracts as part of a joint accommodation strategy with LBH. Our joint approach will embody the principles of recovery, autonomy and value for money in addressing the need for accommodation and psychological support for those who experience chaotic lifestyles including substance misuse

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Executive Summary and Key Points

Performance issues

- **Elective** activity is under plan. There are issues with inpatients but these are primarily due to some short term list clearance in Barts and a reporting issue with UCLH
- **Outpatients** Attendances are over plan – This is being addressed by independent audits at HUH where counting and coding is under query.
- **PTL** – The City and Hackney PTL is over plan (slightly) but primary cause is UCLH where there are reporting issues being addressed:

PTL (A) M4	PTL (P) M4	>52ww (A)
18,290	18,206	3

- Homerton PTL was under plan at M4 – this is reviewed and discussed monthly with the Trust.
- **RTT** at HUH continues to perform well with only Cardiology and Orthopaedics under the 92% target.

Prospective challenges/risks – for 2020/21

- **Learning Disability** Joint funding implementation of our agreed protocol has been slower than anticipated though a robust plan is in place to ensure we meet out planned milestones.
- **NHS** Constitution standards remain on target though we have some fragility on our CHC target and our LD IAF targets. Again, we have robust processes in place to monitor and ensure delivery.
- Significant improvements in our early diagnosis of cancer with a reduction in late presentations (top 10 CCGs in England) and sustained improvement in staging data. We have recently reapplied for Macmillan funding for our GP clinical lead which we are also seeking to add to with additional GP clinical leadership role.

PLANNED CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :

- Community services transformation in Neighbourhood Health and Care for people with long term conditions.
- Transformation of Outpatient services at Homerton.
- Support the mental health and well being strategy; improve opportunities for access to housing for vulnerable and disadvantaged groups; drive an integrated strategy for people with learning disabilities with a strong focus on prevention and reducing inequalities.

Outpatient Transformation

- Virtual clinics for first appointments and follow ups
- Pathway development
- Digital innovation
- Self management support

Personalised care and coproduction

- Ensure coproduction is in place throughout the workstream activities involving residents service users, carers and staff at all levels
- Development of the cross cutting cultural change to support personalised care in our services
- Development of infrastructure to support choice and control across health and social care
- Increase uptake of Personal health budgets (PHBS) and direct payments
- Development of a specific PHB offer to people with learning disability to support new strategy

Neighbourhood health and care services

Supporting the development of the provider alliance to deliver integrated community services at the neighbourhood/network Including:

- Community gynaecology and women's health service
- Community ENT
- Respiratory – integrated community consultant offer increased capacity for pulmonary rehab, early identification, medication support and peer support
- Renal – community consultant input
- Community dialysis
- Community diabetes
- Heart failure service for IV diuretic
- Stroke – recovery and rehabilitation support

- Support the ACN service and the core neighbourhood team in delivery of CHC
- Development of specialist skills and increased capacity – e.g. MH and neuro pathways

Mental Health

- Mental Health neighbourhood transformation programme
- The Provider Alliance
- MDT model for physical and mental health interface

Housing and Accommodation services

- Implement Housing Frist
- Redesign of high needs residential services with ELFT
- Strengthen CHC offer for adult mental health
- Review the role of the ELFT rehabilitation team and if the model could be expanded to support people with Learning Disability returning to local services

Children and Young People (with the CYP Workstream)

- Strengthen our approach to Care and Treatment Reviews and interventions for children and young people with a learning disability or autism – supported by our Darzi fellow

Prescribing

Medicine Optimisation

- Improving transfer of about medicines at hospital discharge
- Pathway updates for anticoagulation

Primary care and primary care networks

- Peer review and audit of referrals by practices
- Network involvement in development of and delivery by the Provider alliance
- Education and support to maintain early diagnosis of cancer and provision of services for cancer survivors for follow up care, screening access and awareness
- Physical health checks and action plans for people with a learning disability

Continuing Healthcare (CHC)

- Continued improvement of local delivery
- Partnership strategic planning for local nursing home provision and funding arrangements
- Implementation of NEL review

Services for people with Learning Disabilities

- ILDS service transformation
- C&H strategy for people with learning disabilities
- Transforming Care Programme (TCP) and Long term plan
- Physical health
- Cost and implement the strategy with a focus on prevention
- Increasing access to mainstream services and asking partners to ensure reasonable adjustments for people with learning disability and autism
- Strengthen our preventative approach in our TCP

Long term conditions (with prevention Workstream)

- Secondary prevention and services supporting people in the community
- Cancer – Early Diagnosis, Faster Diagnosis standard, screening awareness and supporting people in recovery

North East London- System Transformation Priorities:

- Integrated care system development; Outpatients transformation; Surgical redesign

Elective Performance

NHS England Reports activity against plan in SEM data (M4):

Indicator	Planned YTD activity	Actual YTD activity	YTD Activity Last year	% diff from plan	% Diff from last year
EM07: Total Referrals (General and Acute)	**35522**	**35465**	**35738**	**-0.2%**	**-0.8%**
EM07a: GP Referrals (General and Acute)	19960	18837	20479	-5.6%	-8.0%
EM07b: Other Referrals (General and Acute)	15562	16628	15259	6.9%	9.0%
EM08+09: Total Consultant Led Outpatient Attendances	**79963**	**90293**	**83994**	**12.9%**	**7.5%**
EM08: Consultant Led First Outpatient Attendances	25461	28392	27436	11.5%	3.5%
EM09: Consultant Led Follow-Up Outpatient Attendances	54502	61901	56558	13.6%	9.4%
EM21: OPPROC	11101	12879	11592	16.0%	11.1%
EM10: Total Elective Admissions	**8352**	**8385**	**8655**	**0.4%**	**-3.1%**
EM10a: Total Elective Admissions - Day Cases	7361	6994	7545	-5.0%	-7.3%
EM10b: Total Elective Admissions - Ordinary	991	1391	1110	40.4%	25.3%

Homerton activity against plan in SEM data (M4)

Indicator	Planned YTD activity	Actual YTD activity	YTD Activity Last year	% diff from plan	% Diff from last year
EM07: Total Referrals (General and Acute)	**23076**	**22942**	**23358**	**-1%**	**-2%**
EM07a: GP Referrals (General and Acute)	14157	13469	14539	-5%	-7.4%
EM07b: Other Referrals (General and Acute)	8919	9473	8819	6%	7.4%
EM08+09: Total Consultant Led Outpatient Attendances	**44602**	**49591**	**47089**	**11%**	**5%**
EM08: Consultant Led First Outpatient Attendances	16129	18212	17920	13%	2%
EM09: Consultant Led Follow-Up Outpatient Attendances	28473	31379	29169	10%	8%
EM21: OPPROC	2761	2858	2683	4%	7%
EM10: Total Elective Admissions	**5022**	**4867**	**5226**	**-3%**	**-7%**
EM10a: Total Elective Admissions - Day Cases	4533	4318	4697	-5%	-8%
EM10b: Total Elective Admissions - Ordinary	489	549	529	12%	4%

There are still issues with reconciling the SEM activity with SLAM data – there is a specific issue around OPPROC reporting in SEM which is yet to be resolved

Elective Performance

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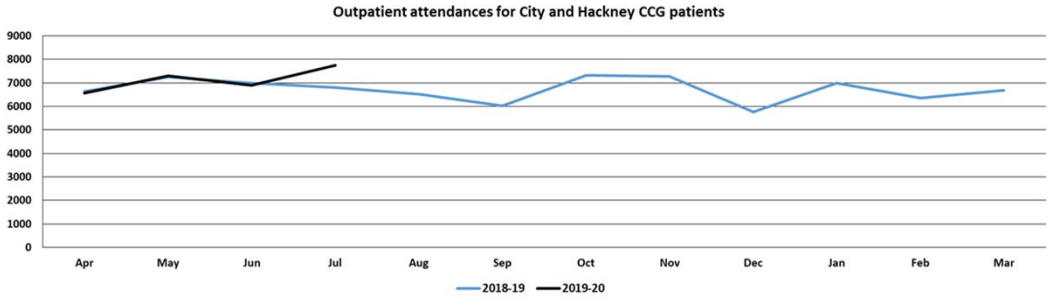
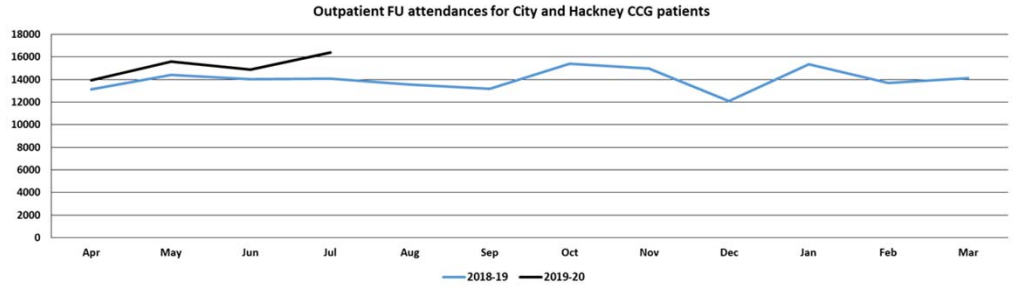
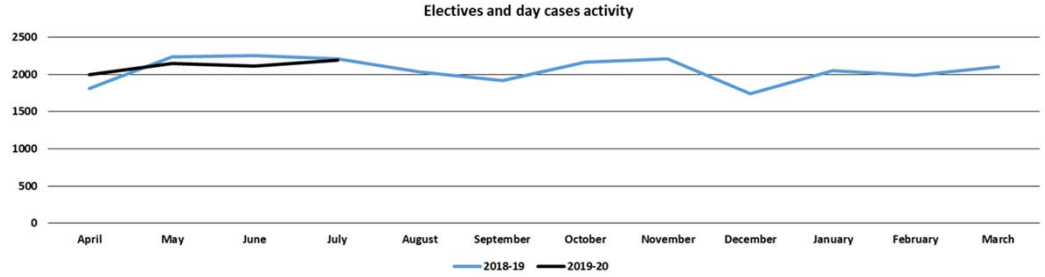
Key issues on performance:

- First Appointment activity is over plan by 12%, however SUS data indicates that activity is less 2.9% over 2018-19 activity. The plan is therefore an issue possibly on distribution of activity and of over-estimating the QIPP amongst other factors
- Follow Up (in NF2F) activity is 13.6% over plan and 9.3% over 2018-19 activity. There has been a 33% increase since last year in NF2F activity yet only 6.9% in F2F.
- Overall Elective & Daycase procedures are 0.7% under 2018/19 activity – see chart

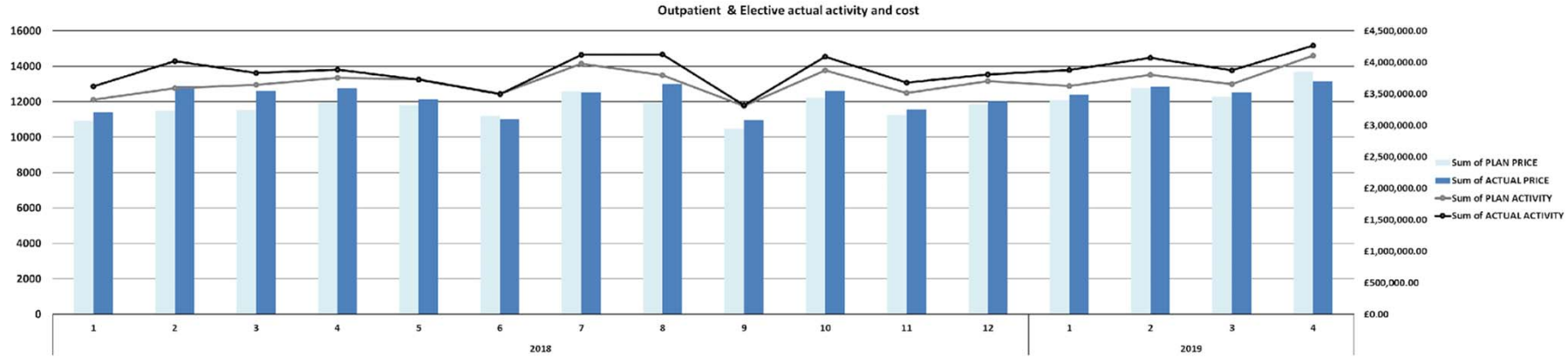






Elective activity at the Homerton - 2019/20 contract

SLAM reports indicate that outpatients are 7% over plan in activity but only 0.6% on cost
SLAM indicates Elective activity 4.8% under plan and costs 0.7% under plan.
Overall Planned Care activity is 5.9% over plan and costs 0.1% over plan.



MAR data issues – HUH MAR continues to show flat growth that is not reflected in First Attendances – this is being discussed along with Appointment Slot Issues (ASIs) that are not being reported to NHSE which indicates a 2-3% under-reporting issue nationally.

PTL – Currently within trajectory – July . This is being reviewed monthly at the Contract Review Group and discussed at the NEL Demand and Capacity monthly meetings.

External Audit Programme 2019 - Auditor appointed and audits have commenced

Outpatient Transformation (HUH) – key successes to date

The Outpatients Transformation Programme is working with 10 specialities and has refocussed on achieving the ambition set out in the Long Term Plan, that: over the next five years **1/3 (or 38k)** of face to face appointments should be delivered virtually or in another way outside of outpatients.

❑ **The programme has identified 8,000 to change so far which represents over 20% of the target. 5000 have either moved or are in progress to move by 2020/21.**

- **Virtual Fracture Clinic (go live July 22 2019)**
  - Total of 668 seen until 24 Sept
  - 70% of FA seen in VFC (1st 3 weeks Sept)

- **Teledermatology (go live June 2019)**
  - 55% of all accepted requests kept within primary care
  - 30 practices trained with further 7 signed up
  - Positive feedback from primary care community

- **Community Gynaecology**
  - Live on eRS (Sep) - 7-10% of activity seen in secondary care deemed appropriate for the community
  - Go ahead given by Neighbourhood Steering Group for pilot of hub and spoke community gynaecology model with one PCN (to commence in Q4 FY19)

- **Rheumatology**
  - Consultants engaged in moving to telephone clinics for follow ups – pilot agreed to commence shortly
  - Agreement to change delivery of Methotrexate injection clinics (approx. 1400 visits a year)

- **Video consultation pilot in Diabetes**
  - Pilot commencing with NHSE to rollout tried and tested video consultation tool Anytime Anywhere
  - Diabetes team have identified c.900 follow ups that could be converted to NF2F appointments

- **Other**
  - Go ahead for digital virtual Msk offer to patients to self manage and refer to be developed for 20/21
  - Sports Medicine discussions on changing delivery model
  - INEL partnership work developing
  - New MsK GP advice and Guidance service

- **Risks**
  - Incentive to maintain momentum of progress (payment mechanism in discussion)
  - Outpatient activity over-performance
  - Project resourcing
    - Only one of 3 HUH transformation project managers have been recruited
  - Senior level clinical engagement from HUH
  - Lack of visibility of progress of IT initiatives

Outpatient Transformation - Current initiatives forecast to deliver by 2021, aligned to LTP

The table below outlines projects initiated or identified to **deliver financial savings and/or support the movement of activity** outlined in the Long Term Plan. Savings identified to date **c.£446k**.

Specialty	Initiative	Description	Activity Change
Covering all specialties	Advice & Guidance Standardised Referral Pathway development and Education	This work is ongoing and across all specialties. We expect this to impact first attendances and by ensuring appropriate referrals to right specialties over the programme timeline. This is also linked to the INEL programme where we are working on specific projects across Barts and Homerton. 5% over 5 years is estimated	First Attendance reduction
Dermatology	Teledermatology	Already rolling out and will have full impact in 2020/21	First Appointments to Virtual
Dermatology	Acne Community pathway	Moving Acne activity to the Community Service. Service to start in Q4 with full impact at the end of 20/21	70% of Activity moves to CHS. 286 First appointments and 857 Follow Ups
Trauma & Orthopaedics	Virtual Fracture Clinic	New model of virtual review of all eligible patients. Started in July 2019 and full impact will be 20/21	70% of all first attendances will move to virtual at lower tariff
Gynaecology	Community e-RS	Community Gynae to be maximised by e-RS referral	Estimated 147 first and 95 follow up moves to community service
Diabetic Medicine	Virtual Follow ups	Conversion of follow ups to virtual via a skype clinic	Follow ups move to virtual - costs are not clear but expected to be no more than 85% of tariff
Rheumatology	Scheduled Telephone Clinics	Changing some types of appointments - Piloting in 19/20 estimated 3 per week.	Follow up to Virtual
Rheumatology	SC Methotrexate Pathway	Changing the way the current clinics are managed to provide alternative to hospital attendance in 20/21	Change to primary care or community service
Ear, Nose & Throat	Community links	ENT links to community service to be strengthend - more routine to be moved to community in 20/21	Estimated 100 firsts and 50 follow ups to move to community
Colposcopy (Gynae)	Patient/GP education	Reduce wasted first appointments	Eliminating wasted appointments
Sports Medicine	To be advised	We are reviewing need for secondary care service over community models	Opportunities to consider moving some or all activity to different model
General Medicine	Not identitified	Reviews have refreshed pathways but small service	N/A
Gastroenterology	To be advised	Reviews only just started	To be advised

Outpatent Transformation - Current initiatives aligned to Planned Care plan on a page

The table below outlines the full breadth of projects under the HUH Outpatients Transformation, aligned to the four core pillars of change: virtual clinics, pathway development, digital innovation and self management support. Bullet points in **bold** represent initiatives that cross over into **neighbourhood health and care services, mental health and primary care networks.**

Specialty	Virtual Clinics	Pathway development	Digital innovation	Self management support
Dermatology	• Teledermatology (900 FA p/a)	• Community isotretinoin pathway, including dispensing in community • One Stop 2ww clinics		
T&O	• Virtual Fracture Clinic (2561 FA p/a) • PROMS led virtual clinic (shoulder pilot being explored)	• Sports medicine optimisation through Locomotor • MDT working	• **Locomotor online self referral tool**	• Detailed patient guidance on exercise and management of injury post first virtual appointment – sent by email and post
Gynaecology		• **Community service on ErS** • One Scope hysteroscopy clinics • **WH Transformation** • Inappropriate colposcopy referrals		
Diabetes	• NHSE 'Anytime Anywhere' virtual consultation pilot (600 FU p/a)	• Oral meds intensification pathway	• Digital solutions to improve outcomes: Disaend (in the community) & Oviva	• Piota, HelpDiabetes, MyDiabetesMyWay
Cardiology		• Implantable Loop Recorder pilot • New pathways – palpitation, AF and syncope • Escalation of abnormal GP open access results		
Rheumatology	• Scheduled telephone clinics for FUs e.g. Osteoporosis/ MBD	• Administering methotrexate in primary care/ community	• Patient initiated follow-ups (if capacity freed up through methotrexate initiatives	
Gastroenterology	• Remote consutlations for IBD, caeliac & IBS patients	• Pilot vetting of outpatient routine referrals	• Digital platforms for remote monitoring, e.g. Jensenn	
ENT		• **Move routine activity in the community** • Direct access and single point of access through Audiology	• Cupris – smartphone otoscope for Advice & Guidance	
All specialties		• Advise and Guidance • Streamlining DMARD shared care pathway • Clinical pathways, **including IAPT for primary and secondary care** • GP education • Flagging additional requirements for patients with LD	• Digital communication with patients • Virtual consultations	

INEL Outpatient Transformation

C&H is working collaboratively with the INEL Outpatients Transformation (Barts), to identify further areas of improvement and share learnings. City & Hackney are leading the Learning system workstream:

Objective

To develop a programme for multi-professional shared learning, bringing together clinicians (across primary, secondary, community care & mental health), commissioners and providers to support improvements in outpatients referral quality, reducing variation and promoting the sharing of learning and experience

Scope

1. Review of current and best practice learning models within outpatients
2. Identification of learnings from INEL outpatients transformation (all workstreams) & HUH transformation
3. Development of education framework and plans across all specialties based on learnings, feedback and best practice

Current Focus

The initial focus is on completing a baseline review of how each of the CCGs and providers approach learning and development in the context of outpatients transformation. The finding from this will help inform a 'best practice' education framework.

Theme	Questions
General	• At a high level, how would you categorise the education carried out in your CCG, e.g. Lunch and learns, masterclasses, e-learning? ○ How often are these events run? • Is the education agenda set at speciality level or workforce level (i.e planned care)? • Is their consistency in approach across each speciality? • What does the planning cycle look like for education?
Roles and responsibilities	• How is educational content decided? • What is the role of the clinical leads/ GP tutors? • Is there a particular person in the provider organisation who supports the planning/ logistics of education? • Is there a particular person in the CCG who supports the planning/ logistics of education?
Digital	• How does the CCG use technology to aid the accessibility of and or effectiveness of education sessions? • Is there any reason why technology is not more widely used to facilitate education? • Can GPs sign up online to education events and does it lead certificates of attendance?
Comms	• How do you ensure potential attendees know about the events? • How do attendees feedback on the events? • Is feedback shared with the presenters? • How do you communicate with out of borough CCGs about issues impacting hospital performance, e.g. inappropriate referrals?
Incentives	• What incentive models do you use to promote attendance? • What incentive models do you use to promote the sharing of learnings with GP colleagues who didn't attend an event? • Are GPs accredited if they watch back education sessions online?
Measuring success	• How do you measure success/outcomes? What metrics do you currently track? • Do you have a view of attendance rates at event?
Reflection	• What works well? • What would improve the education process?

Neighbourhood Health and Care Services

Women's Health Service

The Women's Health Transformation Programme WHTP aims to develop a model of integrated community based care responsive to the women's needs within City & Hackney. This would ensure that the service is delivering value for money, improve patient access to services and patient experience. It also supports the recommendation from The Royal College of Obstetrics and Gynaecologists that investigations and much of the management of gynaecological problems could take place outside an acute hospital setting.

The following list includes main outcomes of the WH programme:

- Increased uptake of the national cervical screening programme
- Early detection, referral and treatment of cervical cancer
- Improvement in the symptom severity of gynaecological problems
- Reduction in inappropriate referrals
- Positive patient experience with the service
- Integrated provision of primary care psychology, mental health services, domestic violence services, alcohol and drug services, community menopause services, psychosexual services, physiotherapy and weight management services.
- Increased GP satisfaction, confidence and competence of the GPs managing gynaecological referrals
- Equitable care regardless of point of access
- Greater proportion of patients with care provided at a single point of access with integrated provision where feasible and seamless pathways into other services.

Community ENT – We aim to develop a services with the networks that is integrated with secondary care services so a more joined up approach is delivered across the system.

Latent TB Services
A PHE commissioned service from CCGs. We have now been commissioned the GP GP Confederation to deliver this ensuring a more joined up approach across primary care. In last 12 months GP practices have screened more than 150 patients for Latent TB with 30 testing positive- an increase of more than 200% on the year before. Further increases are expected going forward helping to reduce and eventually eliminate TB infection in City and Hackney.

Neighbourhood Health and Care - Long Term Conditions

Plans for community services and secondary prevention

Respiratory:
Plan to increase capacity in **Pulmonary Rehabilitation** (PR) – an evidence based intervention for chronic respiratory conditions. The impact of PR includes decrease in number of acute disease exacerbations; reduction in hospital admissions and attendances and an increase in healthy years of life. Currently there is a significant waiting list which is impacting on attendance and completion rates. The City and Hackney Pulmonary Rehabilitation service is applying for accreditation – which involves a rigorous application of standards and if successful, will be one of the first services in the country to achieve this.

Phase IV rehabilitation – Maintenance phase following discharge from cardiac and pulmonary rehab - maintains gains from earlier phases of rehab and reduces readmissions to the programme. Restarted in July 2019 and is the only service in the UK to offer an integrated (joint cardiac and respiratory) phase IV programme. We also require additional capacity in this service to meet demand.
Ultimately the vision is to provide more specialist care in community settings through upskilling of primary care in networks and education provided via an integrated community based consultant to lead the community service.

Heart Failure (HF)
A plan has been developed to pilot a community iv diuretics service and extended hours (to align heart failure provision more closely to the respiratory model). This will offer care at home to patients who would otherwise face lengthy admissions to hospital. This has been successfully trialled in other areas and will increase the capacity and skill base of the specialist HF team. As well as improved quality of life for patients the impact should be reduced unplanned admissions to hospital.

Stroke Services

In 2020/21 we will commence redesign of post stroke care services (Stroke Project, Fit for Health) and alignment with the neighbourhoods community services work. Engagement work with residents so far suggests they highly value ongoing support in the community following stroke and continue to experience issues with meaningful occupation, mood and isolation. We will need to develop a sustainable model which might include increased peer support and supported self-management as well as links to vocational rehabilitation and supported employment services. Secondary prevention (e.g. blood pressure monitoring, dietary advice and exercise opportunities) will need to be important elements of the service.

Neighbourhood Health and Care - Long Term Conditions

Renal

Planned Care would like to consider a community based dialysis service (e.g. at Kenworthy Road). Demand for dialysis is increasing and patients currently have to be treated at the Royal London or Royal Free. This service would offer care closer to home and improve quality of life for this group of patients. Linked to this and the highly successful Virtual CKD service, the renal team are keen to explore the case for a community kidney consultant who would work with primary care teams to increase the complexity of care that could be managed outside the hospital setting.

Diabetes

As part of the Long Term Plan, there will be a significant increase in the number of places provided by NHSE for the National Diabetes Prevention Programme (NDPP) from April 2020. City and Hackney will need a programme of work to drive uptake to meet these ambitious targets.

In the diabetes community service, the specialist nurses and dietitians are realigning their services to PCNs. As part of our re-launched SLA with practices, each practice is being offered an education session linked to case reviews – feedback so far is positive. We would like to build on this to establish increased specialist community support in the future through MDT meetings and education in primary care. Digital offers for diabetes are being reviewed as part of the Outpatient Transformation programme.

Long Term Conditions: Cancer

Improving early diagnosis and detection

qFIT implementation in primary care as a diagnostic
This has been rolled out to GP from April and has now reached its expected activity. There has been no reduction in endoscopies so far, however, it is expected that the roll out has increased GP awareness and this may take effect later in the year.

GP-led Prostate Cancer Stratified follow up
Contract and process now agreed with GP Confederation and Homerton (HUH). Commencement in Oct 2019.

GP Cancer lead progressing feasibility of **breast cancer stratified follow-up**

Bowel screening: qFIT test implemented from July 2019 now only requires one sample and expected to drive a 6-9% increase in uptake.

Cervical Screening: Now being tested for HPV and ongoing cervical dependant on Positive or negative results.

Diagnosis: Success Story

Cancers diagnosed at late stage (4)

- Latest PHE data on cancer diagnosis shows City and Hackney have improved late diagnosis (Stage 4) from 31% to **22%.**
- A HSJ article published in September shows City & Hackney now **6th lowest rate in England** and are **2nd lowest rate in London**
- City and Hackney CCG now below national average of 27% and have the **lowest percentage of late diagnosis in North East London**.

Cancers diagnosed at an early stage (1 & 2)

- As reported through the NHS England Oversight Framework we are achieving 58% of cancer diagnoses at stage 1 and 2 which puts City and Hackney CCG as the **13th highest in England** and the **highest achieving CCG in North East London**

Zolodex - Aim to deliver some breast cancer patients regular injections in primary care freeing up specialist nurse time in HUH and providing care out of hospital

Long Term Conditions: Cancer

Population Awareness - Early Diagnosis Initiatives

Increasing Bowel Cancer Screening Uptake

Targeted project working with Black African / Black Caribbean population by Community African Network.

- Recruitment of volunteer community health champions
- Targeted face to face community outreach
- Targeted engagement through a GP practice
- Production and distribution of promotional materials

Pilot: Kingsmead Health Centre

- **10 community champions** trained
- **3000 individuals reached** through targeted outreach
- **326 telephone contacts** through GP with **105 agreed to screen** following call and **63 replacement kits ordered**
- Reported an **10% absolute increase (25% relative increase)** in bowel screening uptake from 44% before intervention to 54% post-intervention (C&H average remained constant at around 43%)

- Since May 2019 – reached 346 people through outreach
- 4 events @ Richmond Road GP, Lower Clapton GP, Hoxton Market and Ridley Rd Market
- CAN volunteers starting in Latimer Health Centre on 02 October

Cancer Symptom Awareness project

Commissioned LBH and Social Action for Health to deliver community engagement and social media campaign to raise awareness of abdominal symptoms as a sign of cancer in the Black African / Black Caribbean community

- Social media campaign (LBH) to target younger age group – to encourage better health seeking behaviours and act as inter-generational bridge to older members of family/community
- Community engagement (SAfH) volunteers to target older age group face-face.
- LBH / SAfH currently co-developing messaging for campaign – expected community engagement to start October/November.

NEL Prostate Cancer awareness project

Targeting Black African / Black Caribbean population delivered by Orchid to complete series of roadshows and awareness raising events:

- **07 Jun** Kingsland Shopping Centre
- **02-08 Sep** Male Cancer Awareness Week
- **06 Sep** Awareness talk @ Wally Foster Community Centre
- **27 Sep** Awareness talk @ Claudia Jones
- **26 Oct** Community event @ Stoke Newington Methodist Church

Long Term Conditions: Cancer

Cancers diagnosed at Stages I and II

CCG	Stage 1 or 2 (FY2015-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q1) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q2) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q3) 1 yr rolling ave.	Stage 1 or 2 (FY2016-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2017-Q1) 1 yr rolling ave.	Stage 1 or 2 (FY2017-Q2) 1 yr rolling ave.	Stage 1 or 2 (FY2017-Q3) 1 yr rolling ave.	Stage 1 or 2 (FY2017-Q4) 1 yr rolling ave.	Stage 1 or 2 (FY2018-Q1) 1 yr rolling ave.
Barking & Dagenham	41.0%	42.0%	44.0%	45.0%	47.0%	52.0%	52.0%	53.0%	51.1%	49.8%
City & Hackney	52.0%	50.0%	48.0%	49.0%	51.0%	55.0%	55.0%	57.0%	57.4%	54.6%
Havering	46.0%	45.0%	47.0%	49.0%	50.0%	51.0%	50.0%	49.0%	48.8%	50.6%
Newham	48.0%	47.0%	49.0%	50.0%	51.0%	53.0%	51.0%	51.0%	52.0%	51.6%
Redbridge	51.0%	49.0%	50.0%	49.0%	50.0%	52.0%	53.0%	52.0%	52.5%	54.9%
Tower Hamlets	47.0%	45.0%	51.0%	54.0%	54.0%	56.0%	52.0%	50.0%	49.7%	51.7%
Waltham Forest	55.0%	55.0%	54.0%	56.0%	57.0%	60.0%	59.0%	57.5%	57.3%	55.6%
WELC	51.2%	49.7%	50.5%	52.2%	53.4%	55.9%	54.6%	54.2%	54.6%	54.6%
BHR	46.5%	46.0%	47.6%	48.2%	49.5%	51.3%	51.5%	50.8%	50.6%	52.2%
NEL	48.8%	47.8%	48.9%	50.2%	51.4%	53.6%	53.0%	52.5%	52.6%	52.9%
National Average (England)	52.0%	52.0%	52.0%	52.0%	52.0%	52.0%	52.0%	52.0%	51.8%	51.8%

Diagnosis through Emergency Presentation

August 2019

CCG	Diag thru Emergency Presentation FY2015-Q4) 1 yr rolling ave.	Diag thru Emergency Presentation FY2016-Q4) 1 yr rolling ave.	Diag thru Emergency Presentation FY2017-Q1) 1 yr rolling ave.	Diag thru Emergency Presentation FY2017-Q2) 1 yr rolling ave.	Diag thru Emergency Presentation FY2017-Q3) 1 yr rolling ave.	Diag thru Emergency Presentation FY2017-Q4) 1 yr rolling ave.	Diag thru Emergency Presentation FY2018-Q1) 1 yr rolling ave.	Diag thru Emergency Presentation FY2018-Q2) 1 yr rolling ave.	Diag thru Emergency Presentation FY2018-Q3) 1 yr rolling ave.
Barking & Dagenham	25.6%	24.3%	21.2%	20.8%	19.7%	18.9%	18.1%	19.9%	19.2%
City & Hackney	17.9%	24.0%	22.7%	21.8%	19.4%	19.1%	18.3%	17.6%	17.4%
Havering	21.1%	20.7%	19.9%	19.8%	19.2%	19.0%	17.2%	17.5%	17.5%
Newham	23.5%	20.1%	22.5%	21.1%	22.0%	23.6%	22.3%	22.3%	22.4%
Redbridge	21.4%	20.2%	20.4%	19.5%	18.5%	19.1%	18.7%	19.4%	19.8%
Tower Hamlets	26.9%	22.9%	24.6%	25.1%	23.2%	23.4%	19.1%	19.1%	21.4%
Waltham Forest	19.8%	21.1%	20.6%	20.4%	22.2%	22.8%	23.6%	24.5%	22.3%
WELC	21.6%	21.9%	22.5%	21.9%	21.7%	22.2%	21.4%	20.5%	20.2%
BHR	22.2%	21.3%	20.4%	19.9%	19.1%	19.0%	17.9%	17.9%	17.2%
NEL	21.9%	21.6%	21.4%	20.9%	20.4%	20.6%	19.8%	19.1%	18.8%
National Average (England)	19.9%	19.5%	19.4%	19.2%	19.1%	19.1%	18.8%	18.7%	18.7%

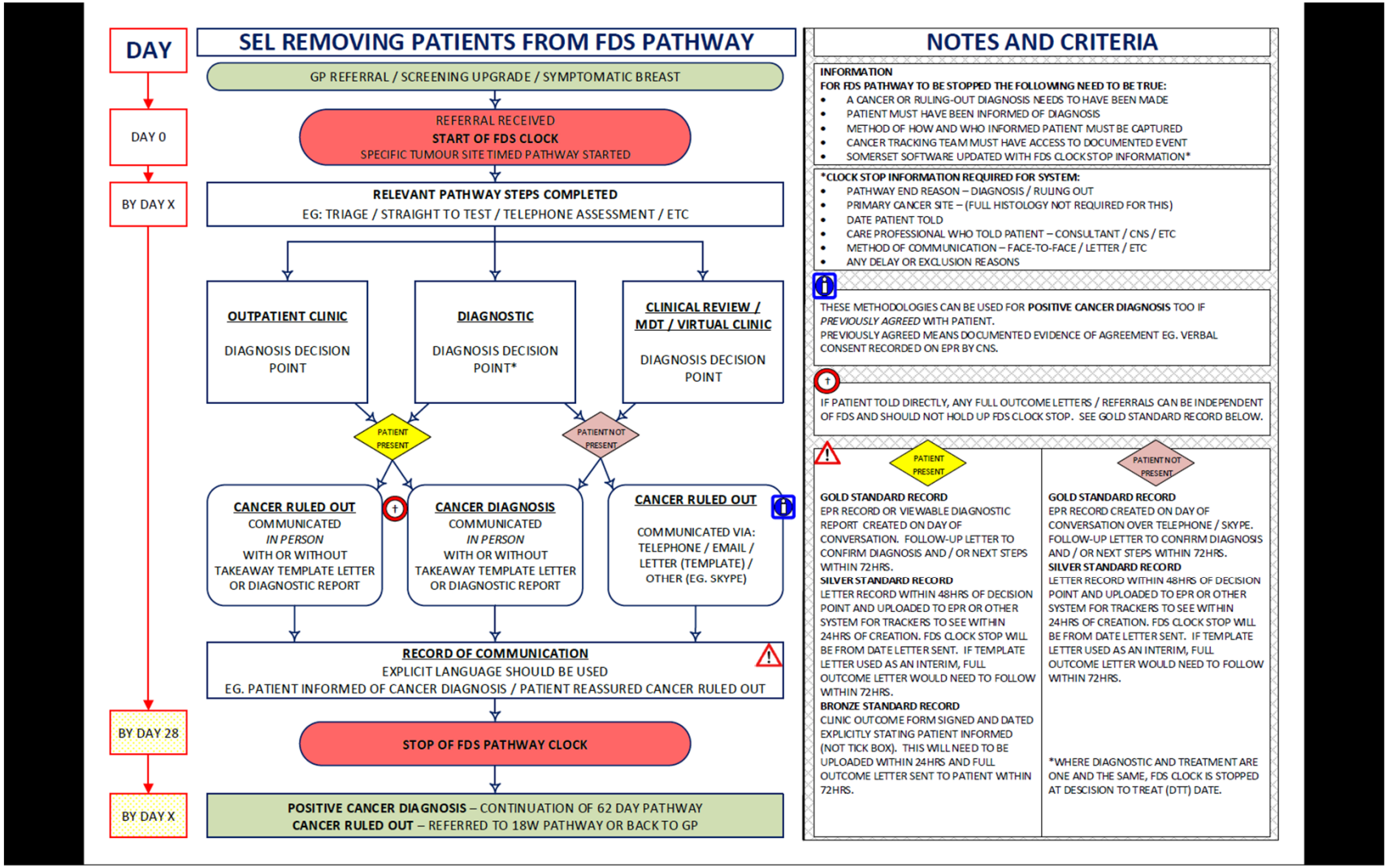
Long Term Conditions: Cancer

Cancer Waiting Times - Initial Report

May 2019

Description	Two-Week Wait		31-Day Wait				62-Day Wait			
	All Cancers	Symptomatic Breast Pts	1st Treat	2nd/Sub (Surgery)	2nd/Sub (Chemo)	2nd/Sub (RT)	Urgent Referral Shared (50:50)	Urgent Referral	Screening	Cons Upgrade
Operational Standard	93%	93%	96%	94%	98%	94%	85%	85%	90%	N/A
Trust Name										
BARKING, HAVERING & REDBRIDGE UNIV HOSPITALS	88.9	96.2	97.2	100.0	100.0	100.0	77.9	76.2	87.5	90.0%
BARTS HEALTH	97.2	96.1	99.3	98.5	100.0	98.3	84.5	85.0	88.9	92.7%
HOMERTON UNIVERSITY HOSPITAL	96.8	95.4	100.0	100.0	100.0		92.9	89.3		100.0%
NEL STP Area (Providers)	94.1						82.5	81.5		
ROYAL FREE LONDON	90.2	90.9	97.3	93.9	100.0	100.0	77.0	74.0	96.8	94.7%
UNIVERSITY COLLEGE LONDON HOSPITALS	90.3		96.1				69.1	75.3	100.0	84.6%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	93.1	92.6	97.8	75.0	92.9		76.7	74.7	93.3	96.2%
CCG Name										
NHS BARKING AND DAGENHAM CCG	87.5	97.8	98.3	100.0	100.0	100.0		75.0	0.0	71.4%
NHS HAVERING CCG	89.6	93.6	95.7	94.1	100.0	97.0		76.9	100.0	96.2%
NHS REDBRIDGE CCG	90.3	95.8	95.4	94.7	100.0	100.0		75.6	71.4	94.1%
NHS CITY AND HACKNEY CCG	96.2	94.7	100.0	100.0	100.0	100.0		90.3	87.5	100.0%
NHS NEWHAM CCG	97.4	98.7	100.0	100.0	100.0	100.0		90.9	100.0	90.0%
NHS TOWER HAMLETS CCG	96.7	92.6	100.0	100.0	100.0	100.0		80.0	100.0	100.0%
NHS WALTHAM FOREST CCG	97.2	96.1	98.8	94.4	100.0	95.2		81.4	66.7	90.0%
NEL STP Area (Commissioners)	93.7							80.1		
NHS WEST ESSEX CCG	92.6	94.0	97.5	86.7	92.0	97.3		78.9	90.9	96.4%
Regional and National Performance										
National *(England)*										
UCLH Cancer Collaborative Area *(Trusts: NC&EL+PAH)*	92.8	93.6	97.8	97.4	99.6	98.9	78.3	78.2	94.1	92.4%
London Area Performance *(Trusts: London)*	93.3	94.4	97.0	96.8	99.4	97.6	79.6	79.7	89.8	86.5%

Long Term Conditions: Cancer – Faster Diagnosis

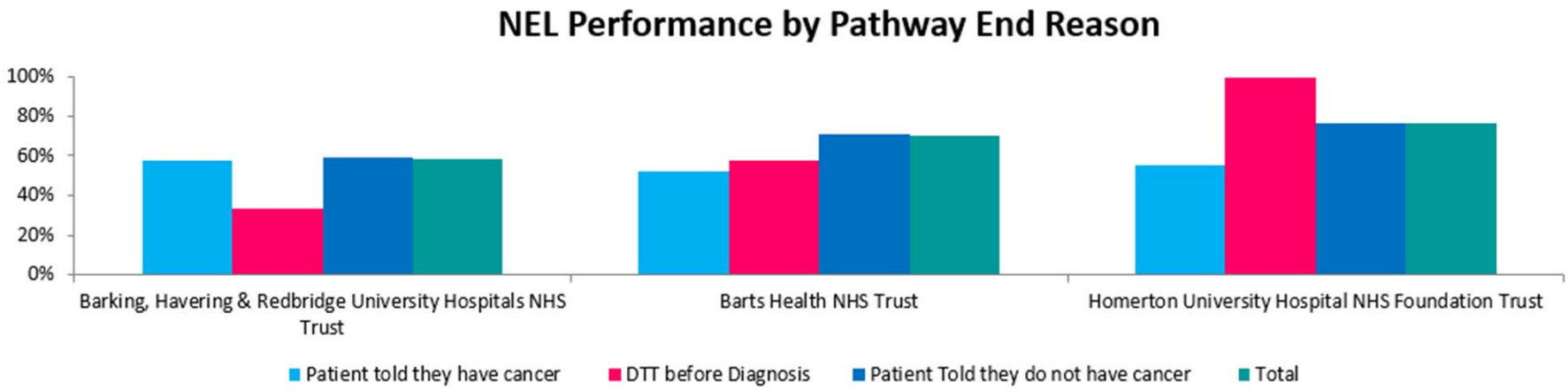


Long Term Conditions: Cancer – Faster Diagnosis

FDS Performance Across NEL –June 19 – All tumour types/routes combined

NHS
UCLH Cancer Collaborative
The Cancer Alliance for north and east London

Provider	Jun-19											
	Patient told they have cancer			DTT before Diagnosis			Patient Told they do not have cancer			Total		
	Total	Breaches	Performance	Total	Breaches	Performance	Total	Breaches	Performance	Total	Breaches	Performance
Barking, Havering & Redbridge University Hospitals NHS Trust	63	27	57%	45	30	33%	1,998	823	59%	2,105	880	58%
Barts Health NHS Trust	65	31	52%	47	20	57%	2,613	771	70%	2,716	821	70%
Homerton University Hospital NHS Foundation Trust	31	14	55%	1	0	100%	1,022	240	77%	1,054	254	76%
NEL STP Total	159	72	55%	93	50	46%	5,633	1,834	67%	5,875	1,955	67%



Continuing Health Care

- Continued improvement of local delivery with Homerton, NEL CSU and local authority partners
  - The addition of the Brokerage Lead has increased the capacity within the clinical team and performance has improved on delivery of the 3-month and 12-month reviews.
  - There has been significant effort between the CSU and clinical team to address data quality issues which has provided greater assurance to the CCG.

- CHC quality premium performance remained under national targets during Q1 and part of Q2. The Trust and CSU provide reasons for each breach and this continues to be monitored monthly by the CHC Operational Improvement Group. A couple of actions that will support future performance are as follows:
  - LBH signed a 2-year contract with Manor Farm Nursing Home for 20 beds, an increase of 4 that started in July 2019. This additional capacity should support D2A placements, reducing some assessments taking place in an acute setting.
  - The Nursing Directorate at NHSE/I have also offered to help with the communication process / map the frequency of referrals from out of area acute Trusts.
- Partnership strategic planning for local nursing home provision and funding arrangements
- Work with INEL CCG's to implement recommendations following the INEL CHC review
  - Unified Health and Care were commissioned by INEL CCGs to carry out a CHC Transformation Review between May and August and make recommendations in support of future Integrated Care Systems working. The review set out recommendations for a programme of work over the short, medium and longer term.
  - The meeting on 30th September with commissioning and provider leads has agreed the direction for the next steps on the Transformation Programme which will commence at the end of October.

Continuing Health Care

% CHC assessments in an acute setting (target <15%)

CCG	Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19			Q1 19/20		
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Barking and Dagenham	5.3%	0.0%	4.2%	16.0%	5.9%	0.0%	14.7%	14.3%	8.7%	9.7%	14.3%	8.3%	13.9%	5.6%	13.2%
Havering	0.0%	0.0%	5.4%	28.1%	12.8%	19.4%	17.5%	14.3%	5.7%	5.6%	14.3%	4.2%	9.8%	2.7%	12.7%
Redbridge	0.0%	0.0%	10.7%	3.7%	16.7%	14.8%	14.3%	16.1%	17.9%	3.0%	9.1%	5.6%	13.0%	7.6%	14.3%
City and Hackney	50.0%	42.9%	100.0%	60.0%	66.7%	76.9%	20.0%	20.0%	27.3%	7.1%	16.7%	8.3%	20.0%	33.3%	20.0%
Newham	26.3%	44.4%	43.8%	47.1%	36.4%	40.0%	18.2%	16.7%	20.0%	42.9%	25.0%	0.0%	0.0%	10.5%	0.0%
Tower Hamlets	55.6%	36.4%	30.8%	30.8%	50.0%	28.6%	33.3%	22.7%	0.0%	7.7%	25.0%	36.4%	23.1%	20.0%	16.7%
Waltham Forest	8.3%	10.5%	28.6%	25.9%	15.8%	11.5%	10.0%	7.1%	26.7%	14.3%	10.0%	6.3%	12.5%	22.2%	0.0%
North East London STP	14.5%	15.9%	19.0%	25.8%	22.4%	23.4%	16.9%	15.7%	13.4%	8.4%	14.5%	11.8%	13.3%	8.1%	12.3%
Tolerance level	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*15%*	*115%*

- July - 17% (1/6 and it was clinically necessary)
- August- 14% (1/7)

% CHC referrals completed within 28 days (target =>80%)

CCG	Q1 18/19			Q2 18/19			Q3 18/19			Q4 18/19			Q1 19/20		
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Barking and Dagenham	86.1%	97.4%	82.9%	39.4%	76.0%	32.5%	65.3%	71.8%	65.4%	64.7%	60.0%	70.0%	61.5%	59.6%	70.0%
Havering	94.0%	86.8%	82.0%	67.3%	66.7%	56.8%	60.0%	64.0%	61.0%	60.6%	62.2%	54.5%	58.3%	53.6%	68.3%
Redbridge	85.7%	81.0%	88.9%	64.6%	78.1%	63.8%	65.2%	67.4%	62.5%	53.3%	59.1%	63.3%	56.3%	57.9%	67.2%
City and Hackney	100.0%	90.0%	87.5%	72.7%	63.6%	64.3%	64.3%	69.2%	84.6%	61.5%	92.3%	66.7%	77.3%	75.0%	90.0%
Newham	57.9%	77.8%	90.0%	73.3%	81.8%	90.9%	77.8%	83.3%	72.7%	36.4%	83.3%	88.9%	40.0%	75.0%	47.6%
Tower Hamlets	77.3%	72.7%	64.7%	45.5%	50.0%	50.0%	66.7%	60.0%	30.8%	15.8%	45.5%	46.4%	78.3%	87.5%	100.0%
Waltham Forest	100.0%	68.4%	71.4%	100.0%	100.0%	81.3%	100.0%	84.6%	100.0%	85.7%	100.0%	100.0%	93.8%	100.0%	91.7%
North East London STP	86.3%	83.9%	81.8%	66.0%	71.4%	61.0%	65.2%	68.3%	63.2%	55.7%	65.1%	64.9%	65.7%	62.6%	70.2%
Tolerance level	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*

- July - 89% (8/9)
- August – 63% (10/16)

Learning Disabilities

Summary & Key Points

Integrated Learning Disabilities Service redesign – The service specification was approved at ICB in May 2019. New pathways are being put into place in ILDS. A contract monitoring meeting will be planned for later this year to establish how the service is working toward this new specification.

Leder Reviews, into premature deaths of learning disabled people continue to be completed and reports produced across North East London. The main findings continue to be shared with Providers to support positive changes in supporting to address health inequalities for learning disabled people. However, a shortage of reviewers means there is a significant backlog of work.

Learning Disabilities Strategy - A Leaning Disabilities Strategy to make City and Hackney Learning Disabilities' friendly places was taken to May's ICB. The vision and themes for this were coproduced with The Learning Disabilities Partnership Forum and the direction of travel was agreed by ICB. However, the ICB requested some slight amendments and a costed model of the strategy before it would be approved. Work has been undertaken to look at cost and demand modelling, with a shift towards a more preventative approach and accessible communities. The strategy is scheduled to be taken back to ICB in Nov 2019. Key areas that the strategy will explore and seeks to address will be day opportunities (including employment), ensuring good accommodation, and increased personalisation. These will be key commissioning projects over the next year.

Risks for This Year:

Learning Disabilities TCP - Although two patients were discharged from long stay units last year, the numbers of Specialist Commissioning TCP admissions in 19/20 has increased from two to four inpatients. This is due to Ministry of Justice restrictions and sentencing. Work is also underway to establish processes both for adult and children's TCP cohort to help prevent unnecessary hospital admissions.

Learning Disabilities Leder – There are significant challenges with ensuring that Leder Reviews (reviews to explore preventable and premature deaths of learning disabled people) are completed and done so in good time. Leder Reviews have been included as part of the new ILDS service specification. However, a backlog is currently building and there is a lack of reviewers in City & Hackney to undertake these reviews. The Reviewer that was employed across North East London has now left which will also impact on completion rates.

Learning Disabilities Joint Funding – Following a pilot in 2018, money has been put aside by the CCG for joint funding ILDS packages of care. Though Joint Funding Assessments are now taking place it has been difficult to establish this as part of business as usual and substantial delays to completing these due to reduced capacity in the ILDS team. Since CCG funding is tied to the joint funding assessments being approved there is a significant risk that the identified money will not be allocated before the year's end.

Learning Disabilities

IAF

Learning Disabilities:

Currently there are 1,198 people aged 14+ years on the LD register across City and Hackney GPs who meet the criteria for having an Annual Health Check and Health Action Plan. There is a target set for 75% completion of LD Health checks.

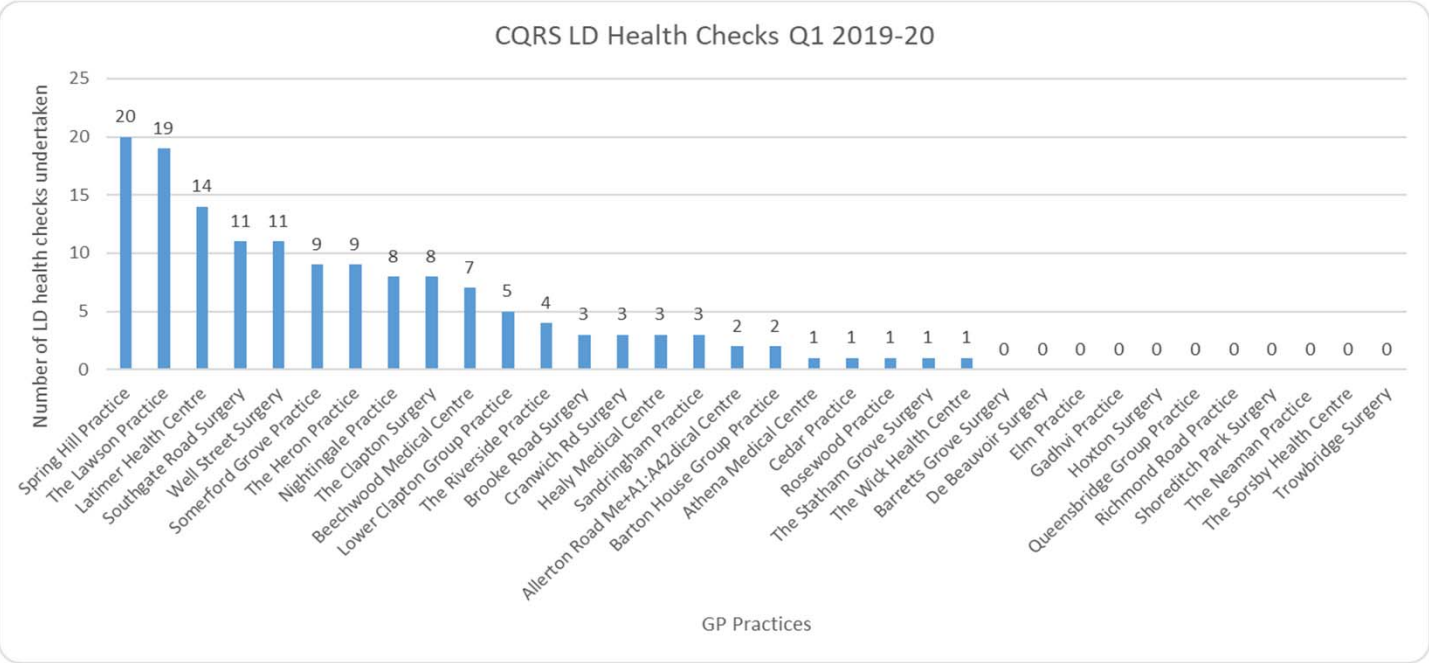
In the most recent data for Quarters 1 & 2 (CEG):

Patients aged 18 and over				
LD patients aged 18Y and over	LD Health Check done (From April 2019)	% of LD patients (18Y and over), with 'LD Health Check done'	"LD Health Action Plan done (of those with 'LD Health Check done') from 1st April 2019"	% of LD patients (18Y and over), with 'Health Check done' and also 'HAP done'
1,107	**376**	**34%**	**362**	**96%**

There remains a discrepancy between the CQRS data (which is used for the National IAF target) and our local CEG data. Anna Garner (Head of Performance) is investigating this.
From the CQRS data, compared with this time last year, the number of overall LD health checks has increased slightly from 102 to 146 (Q1). However there is variation across City and Hackney between GP practices with some practices not having any health checks recorded. Work is underway to raise awareness with practices and regularly remind them about the importance of uploading their data on a quarterly basis including via the Practice Managers forum.
It should be noted that practices do not spread their workload evenly throughout the year so the Q1 position is not necessarily reflective of the end of year position.

Learning Disabilities

CQRS data for Q1 is shown below:



The CCG has submitted a target of 75% of people on the register having a health check in the 2019/20 operating plan, in line with NHSE guidance. Practices are incentivised through the LTC contract to provide health checks and health action plans.

A Darzi Fellow has started in September and will be working in Learning Disabilities. Part of the focus of her role will be looking at registers for LD in Primary Care as well as the quality of health action plans. We are also hoping to appoint a GP clinical lead to help with this work.

Learning Disabilities

Local Alignment and Progress Toward STP Plan

LD Employment – In 2018/19 the employment rate for learning disabled people known to services was 3.4% compared with 72% of overall population in Hackney (ONS, 2018). This rate is lower than a number of other boroughs and the target set of >4%. A LBH Performance Report in Aug 2019 identified 21 out of 518 service users now in paid employment (so 4%). This shows a slight increase and alignment to the ASCOF measure.

The Hackney Council's Supported Employment Service has been established and is working with learning disabled people to find and gain employment and linking with ILDS. Over the past year they have got three people with learning disabilities into paid employment and are working with many more on this goal. A supported employment network is also being established in Hackney which works to get disabled people into paid employment and there is an employment strategy developed (under Prevention workstream).

Stop Over Medication with Anti-Psychotic Medications (STOMP) Programme

In the 2018/19 audit City and Hackney and other boroughs in North East London scored a red in the NHSE STOMP audit with a number of areas highlighted for improvement. Though in part this was due to problems with data submission in the audit itself, an action plan is being developed to address the key problem areas highlighted. A specific audit is being undertaken by Medication Management Team and Psychiatrists at ILDS & CAMHS around antipsychotic prescribing practices too. This will hopefully ensure good practice is followed in this area.

Learning Disabilities

Workstream Asks

Integrated Learning Disabilities Service (ILDS):
The ILDS redesign is complete with new service specification in place.
An accommodation review of placements for learning disabled people was undertaken. This looked at where people were placed and opportunities to move people into settled accommodation. The new ILDS will review and work on move-on for such clients over the next two years.

Joint Funding
A joint funding pilot was completed to establish an assessment tool and process. A policy has been devised and agreed between commissioning and operations (pending formal sign off). Training was delivered to the ILDS staff team at the end of April.
The business as usual process has commenced. Commissioners have supported this with additional training, weekly funding review panels and regular feedback to the team on quality of the assessments. However, due to a lack of permanent staff being in place within ILDS there are delays to progress.
Work has begun on modifying the Mosaic notes' system to ensure there is a process on it suitable for charging and preventing client contributions for health. Money has been provided via the IT Enabler fund for this work to take place.

Table: LD Joint Funding Situation (Sept 2019)

Number of packages agreed for Joint Funding	2
Number of packages rejected for Joint Funding	2
Number of packages deferred to multi-disciplinary team for further information	6
Total number of packages reviewed by Joint Funding Panel	10

Coproduction - The Learning Disabilities Partnership Forum continued and is currently being evaluated. This provided a forum for co-production. Work from this was used to inform and develop both the strategy and the specification for ILDS. The annual Big Do event was held in Sept this year and will help coproduce the strategy's action plan and priorities.

The learning disabilities' provider forum was set up and continues. This is a forum for providers and commissioners to improve and develop LD services. Providers have also been invited to contribute to a blog to shape the London Borough of Hackney's market position statement which will include learning disabilities (as part of joint commissioning function).

Mental Health

National NHS England Retrospective performance summary - City and Hackney achieved full compliance and exceeded national targets in most areas

NHSE indicator	NHSE Target	CH Q4 18/19 performance	Comment
IAPT Recovery rates	50%	56.89%	City and Hackney recovery rate was 56.89% in 2018-19 Q4 (top 10% in London ranked 2nd)
BAME IAPT Recovery rates	50%	76.4% (Bikur Cholim) 73.4% (Derman)	Bikur Cholim recovery rate 76.4% (ranked 1st) and Derman 73.4% (ranked 2nd) across London.
IAPT Access rates	4.34%	5.8%	City and Hackney IAPT Access rate at the end of 2018-19 Q4 was 5.8% (top 12% in London ranked 3rd)
IAPT Waiting times	75%	96%	Our waiting times at 6 week was 96% at the end of 2018-19 Q4, against a target of 75%

2020/21 Planned Care Mental Health Systems Intentions

PHBs. We will review the results of the Personal Health Budget pilot and determine how we will commission PHBs recurrently.

Section 117. Both the CCGs and the Local Authorities have a shared responsibility for s117 and we therefore need to establish a joint process for s117 patients. Patients on s117 will also have a right to PHBs. NHS and Local Authority Commissioners need to determine the scope of PHBs funding in relation to the wider 117 package.

IAPT. Will be expanding IAPT services in line with the NHSE increased access target of 25% by Q4 2020-21. We will continue to develop our IAPT specialist offer including LTC, autism, perinatal. We would like greater alignment between long term conditions psychology who currently sit outside the IAPT service and the IAPT services to ensure and integrated pathway. As a primary care based service IAPT will be a central part of the neighbourhood mental health offer for people with common mental health problems. The IAPT service will therefore need to be aligned to neighbourhoods and the new neighbourhood teams which are being funded through the NHSE Community Transformation funding. Neighbourhood working offers an opportunity for the service to develop greater links between physical health and the wider determinates of mental health wellbeing.

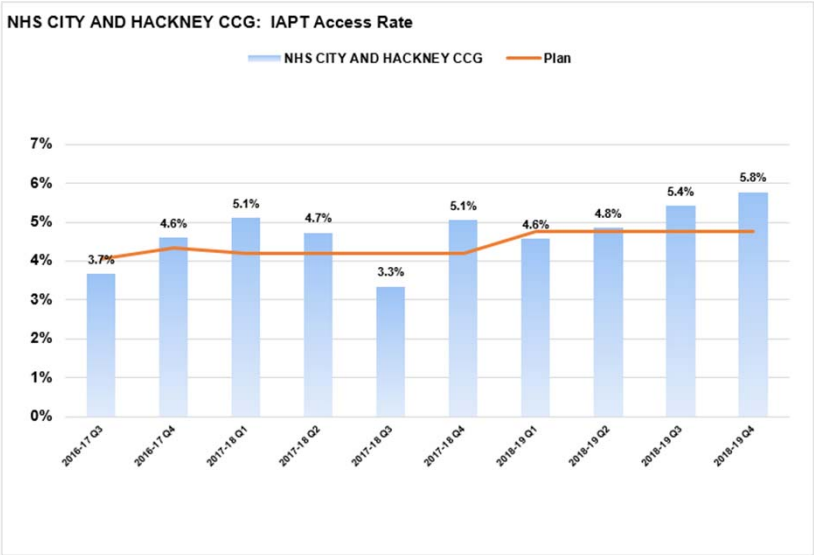
Accommodation pathway. Both the CCG and LBH commission High Needs mental Health accommodation through ELFT who sub-contract to Look Ahead. We also commission a Community Rehabilitation Team that covers both health and social care placements. There is a need to create a joined up local authority and CCG accommodation strategy, which ensures that embodies the principles of recovery, autonomy and value for money and builds on new initiatives such as increasing flexible support. Expected outcomes are:

- ✓ joined up health and local authority approach to mental health accommodation
- ✓ Increased use of floating support
- ✓ Greater throughput in the system with reduced numbers and reduced lengths of stay in high needs areas
- ✓ Greater service user autonomy
- ✓ Improved value for money.

Mental Health

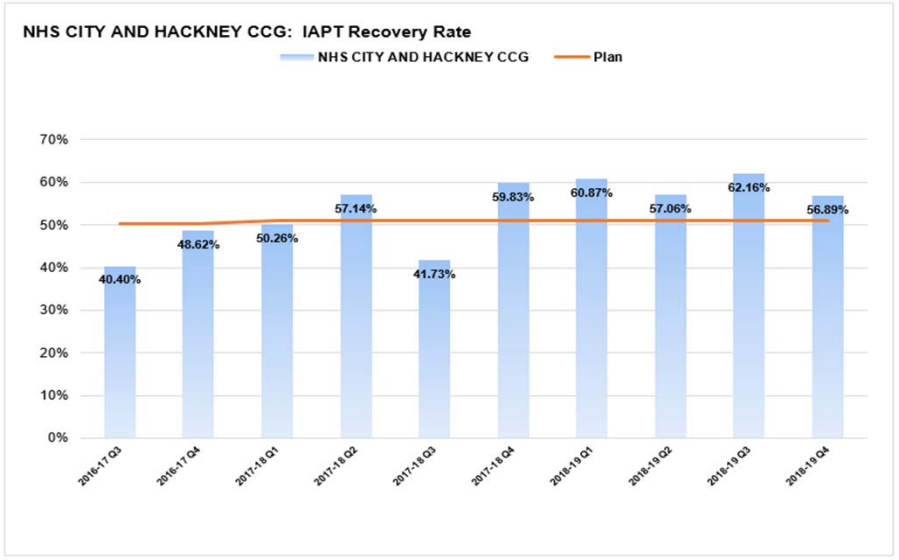
Current performance position against indicators and clinical priority areas

IAPT Access Rate (FY15/15 Q4 - FY18/19 Q4)



City and Hackney IAPT Access rate at the end of 2018-19 Q4 was 5.8%, above the 4.34% target.

IAPT Recovery Rate (FY15/15 Q 4 - FY18/19 Q4)



The recovery rate for City and Hackney CCG service users was 56.89% in 2018-19 Q4, above the 50% target.

Mental Health

NHS England Mental Health LTP requirements 2023/24

Core DRAFT REQUIREMENTS (subject to confirmation w/c 15th July)	City and Hackney Joint Mental Health Strategy 2019-23
OTHER COMMITMENTS	
By 2023/24 an additional 380,000 people per year will be able to access NICE approved IAPT services.	This translates to a local access target of 30% by 2023/24. We are currently working to improve BME access and older adults (65+). Talk Changes has recently appointed a BME/Young Black Men's Lead.
For people admitted to an acute mental health unit, a therapeutic environment provides the best opportunity for recovery. Purposeful, patient-orientated and recovery-focussed care is the goal from the outset. The NHS will reduce the length of stay in units with a long length of stay to the national average of 32 days.	We are looking at reducing Length of Stay as part of the Centre of Excellence Programme looking at built environments.
Ensure that the parts of England most affected by rough sleeping will have better access to specialist homelessness NHS mental support, integrated with existing outreach services.	▪ We are piloting a Housing First Pilot to support and help secure housing tenure for people who are homeless and often have multiple and complex needs. ▪ Pilot with Greenhouse practice, Westminster Drugs Project (WDP) and ELFT to provide secondary care psychological to support to people who are homeless and/or have substance misuse problems. Satellite service planned in the City – to be further discussed and developed with CoL, ELFT and LBH.
Expand geographical coverage of NHS services for people with serious gambling problems, and work with partners to tackle the problem at source.	To be discussed and developed with local providers, prevention workstream, public health teams and the mental health coordinating committee.
Deliver Personalised Care	We will deliver 180 Personal Health Budgets in 18/19 and expanding beyond in 2023/34. We will expand the use of personalised recovery care plans for severe, enduring and complex mental health in neighbourhoods and improve the offer of personalised digital services including online therapies and online support.

Mental Health

Quality Premium

	Quality Premium Measure		Target	Baseline	Weighting
QP4	Mental Health (Option B) Older people and BAME access to IAPT Mental Health	Part 1) Improve IAPT recovery rate of BAME patients; AND	Increase recovery rate of BAME patients by 5% OR same as white British, whichever is smaller in Q4 18/19 AND	n/a	17% Both parts must be met
		Part 2) Improve IAPT access rate of patients over 65	Increase proportion of 65+ accessing IAPT to at least 5.38% (70% proportion of over 65s in local population) in Q4 18/19 (provisional target based on latest data available: 2016 ONS mid-year estimates)	n/a	

Talk Changes Quality Premium data													
Patients entering IAPT treatment (2017/18)	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**YTD Average**
BAME Recovery Rates	50.70%	57.90%	59%	58%	59%	47%	66%	60%	59.30%	45%	53.20%	63.30%	
White British Recovery Rates	68.40%	66%	40.50%	65%	63%	57%	65%	67%	60.50%	55%	69.90%	61.50%	
Target: Q4 17/18 + 5% OR same as white British, whichever is smaller in Q4 18/19													
Patients entering IAPT treatment (2017/18)	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**YTD Average**
18-64 years	391	446	529	456	467	501	620	534	435	533	515	480	
65+ years	14	18	28	20	13	31	23	31	13	19	14	15	
Total access for the month	405	464	557	476	480	532	643	565	448	552	529	495	
Percentage of 65+ entering IAPT treatment	3.45%	3.90%	5%	4%	2.80%	6%	3.57%	5.48%	2.90%	3.44%	2.65%	3.00%	
Provisional target (70% of proportion of adults aged 65+ in local population in 2016 ONS mid-year estimates)	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%	5.38%

Progress Update:

1. BME Recovery – on target
2. 65+ Access target - not on target. Plans and resources in place to increase access rates

Primary Care/Networks

Clinical Commissioning Engagement

- Maintenance of CCE behaviours:
- New Evidence Based Interventions (EBI) Policy
- Advice and Guidance (increase use and coverage)
- Peer Review of Audits
- Standardised Referral Forms (Barts)

- **COPD Audit -** The Pan – Hackney primary care audit this year will focus on undiagnosed COPD in order to inform our approach to meeting the objectives of the LTP in relation to prevalence of respiratory disease and improving quality of diagnosis. City and Hackney continues to have high rates of premature mortality from respiratory disease and a gap in expected to observed prevalence.

Cancer - Faster Diagnosis Standards

- Diagnosis by 28 days from GP referral

Early Diagnosis

- C the Signs commissioning review
- Direct Access Pathways
- Patient Awareness
- Cancer - Healthy Choices campaign

Personalised care and coproduction

- Personal Health Budgets are now the default delivery model for all NHS Continuing Healthcare packages of care at home.
- Mental Health Recovery PHB Pilot is now live and delivered 22 PHBs in first 3 months

PHB Cohort	Number of PHBs (Aug 2019)	Expected by end of Q4 19/20
Homerton CHC PHBs	39	52
ILDS CHC PHBs	18	20
Children's CC PHBs	19	20
Personal Wheelchair Budgets	34	30
Integrated Personal Budgets	1	30
Mental Health Recovery Pilot	22	100
Total	**133**	**252**

- Wheelchair service has been delivering Personal Wheelchair Budgets (PWBs) since April 2019 and already exceeding target for year
- We are on target to deliver overall expected number of PHBs by end of Q4 19/20
- Scoping out feasibility of delivering additional PHBs to other patient cohorts such as End of Life Care and Maternity, which will further increase total PHB numbers

Finance – QIPP 2019/20

Programme	Full Year Plan £000	FOT @ M5 £000	FOT Variance £000	YTD Plan £000	YTD Actual £000	YTD Variance £000	Update	Yearend FOT RISK rating
GP Direct Access - Pathology Improvements	240	240	0	100	99	(1)	No issues	Low
GP Direct Access - Radiology Improvements	26	26	0	11	8	(3)	No issues	Low
PSA Monitoring GP Shared Care	4	4	0	0	0	0	Delayed Start	Low
UCLH reducing FAs and FUPs	100	0	(100)	42	0	(42)	Block	Closed
Out of area referrals (Barts)	30	15	(15)	13	0	(13)		Medium
Ophthalmology Referral Review (MECs Plus) - MEH	45	32	(12)	19	6	(12)	Expected to recover	Medium
Ophthalmology Referral Review (MECs Plus) - Homerton	6	4	(3)	3	0	(3)	Expected to recover	Medium
Teledermatology**	58	42	(17)	17	0	(17)	Delayed Start	Medium
Colposcopy Pathway	54	0	(54)	12	0	(12)	Re-Planned for 20-21	Closed
Termination of Pregnancy	72	245	173	72	245	173	Over Performing	Low
Homerton Methotrexate Pathway	33	0	(33)	14	0	(14)	Re-Planned for 20-21	Closed
Biosimilars - Homerton	420	420	0	260	260	0	No issues	Low
Biosimilars - UCLH	107	129	22	66	66	0	No issues	Low
Biosimilars - Barts	112	142	30	69	69	0	No issues	Low
Primary Care Prescribing Budget	175	175	0	52	52	0	No issues	Low
Quality Premium - Antimicrobial Resistance	140	0	(140)	0	0	0		Closed
GP referral variation - Homerton	59	39	(20)	16	0	(16)		Medium
GP referral variation - Barts	22	15	(7)	6	0	(6)		Medium
GP referral variation - Moorfields	19	13	(6)	5	0	(5)		Medium
CHC - MSNH	150	88	(63)	63	0	(63)		High
FIT testing - Homerton	101	78	(24)	24	0	(24)	NEL expect late year delivery	Medium
FIT testing - Barts	11	8	(3)	3	0	(3)	NEL expect late year delivery	Medium
CHC - Review Non Health CHC packages	400	400	0	167	167	0		Low
Pathology Credit	400	311	(89)	167	130	(37)		Low
Outpatient Transformation - Virtual Fracture Clinic**	0	77	77	0	16	16	Expected to over perform by £30k	Low
Patient Transport -Barts	0	121	121	0	0	0		Medium
Patient Transport -UCLH	0	110	110	0	46	46		Low
	2,785	**2,733**	**(52)**	**1,196**	**1,163**	**(33)**		

Finance – QIPP 2020/21 PIPELINE

Programme	Description	Full Year Plan	Plan for 20/21 Deliver	Status	Risk
20/21 Primary Care Prescribing	Awaiting more detail			Ongoing	Low
CHC Dormiciliary Care Brokerage AQP	Awaiting more detail			Under discussion	
Evidence Based Interventions	Continuing Programme	185	185	BC agreed	Low
FIT testing -Full year effect	Continuing Programme	50	50	In progress	Medium
GP Direct Access - Pathology Improvements	Continuing Programme	164	115	Ongoing	Low
GP Direct Access - Radiology Improvements	Continuing Programme	30	21	Ongoing	Low
Hypertension - Patient Support Programme	Awaiting more detail			Under discussion	
Ophthalmology - Virtual Follow Ups - community	Aim to move 30% of MEH FUs into a community virtual model	17	12	Under discussion	Medium
Outpatient Transformation - Isotretinoin Pathway	Moving 70% of secondary care Dermatology acne patients to the CHS service	21	21	BC agreed	low
Outpatient Transformation - Advice & Guidance/e-RS - improvements (INEL OT Programme)	Increase usage of A & G, standard referral forms and e-RS clinic education.	25	18	Ongoing	Medium
Outpatient Transformation - Colposcopy GP Pathway	30% of GP referral referred more appropriateley reducing Gynaecology First Outpatient Appointments	79	55	Guidance/training in development	Medium
Outpatient Transformation - Community Gynaecology Expansion	Continuing Programme	35	25	Ongoing	Low
Outpatient Transformation - Community Repatriation of Methotrexate Clinics	Current Methotrexate clinic model discontinued for a more flexible primary care community approach	93	65	Principle agreed	low
Outpatient Transformation - Diabetes Virtual Follow Ups	Skype type clinics for follow ups moving 600 appoiointments per year	16	11	BC in development	Medium
Outpatient Transformation - ENT - Community service change	The new community service offers a different model with stronger HUH links	15	15	In progress	Low
Outpatient Transformation - Rheumatology Virtual Follow Ups	Specific Consultant Telephone Clinics	6	4	BC in development	Medium
Outpatient Transformation - Sports Medicine - Physio Pathways	A & E redirect from Sports to Locomotor Pathway	50	25	Under discussion	Medium
Outpatient Transformation - Teledermatology	Continuing Programme	35	35	Ongoing	Low
Outpatient Transformation - Virtual Fracture Clinic	Continuing Programme	49	49	Ongoing	Low
Patient Transport - Homerton	Awaiting more detail			Under discussion	
PSA Monitoring GP Shared Care	Continuing Programme	2	2	Ongoing	Low
Secondary Prevention Programme Heart Failure - Community Based IV diuretic Service	Awaiting more detail			Under discussion	
Secondary Prevention Programme Respiratory - Increasing uptake of Pneumonia Vaccine	Awaiting more detail			Under discussion	
		872	708		

Integrated Commissioning Glossary

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.
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.
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.
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.
	Multidisciplinary/MDTs	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.
	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.
	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.
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.
	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.
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.
	The City	City of London geographical area
CoLC	City of London Corporation	
	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.
	Commissioners	City and Hackney Clinical Commissioning Group, London Borough of Hackney, City of London Corporation
CS2020	Community Services 2020	The programme of work to deliver a new community services contract from 2020.
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.
LBH	London Borough of Hackney	
NHSE	NHS England	

NHSI	NHS Improvement	
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.
CPA	Care Programme Approach	
CYP	Children and Young People's Service	
LAC	Looked After Children	

IC Governance Review Implementation Plan – Update October 2019

RAG System **Green = completed / proposed to close** **Amber = on track**

Red = delayed / not delivered

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
1.	**The Transformation Board will refocus its work to have a stronger emphasis on wider stakeholder engagement and transformation**	Hold a workshop with TB members to explore how TB could be refocused ToR for 'Transformation and Engagement Group' developed and agreed across partners. First meeting of the 'Transformation Group' held and forward plan agreed.	End Jan 2019 March 2019 May 2019	Carol Beckford Jonathan McShane Jonathan McShane	Completed. A workshop facilitated by Sue Goss was held on 27 February 2019. In progress. Meeting held on 27 April 2019 and the Group is considering its forward plan. Next meeting of the board is 17 July. Complete
2	**An Accountable Officer Group (AOG) will be formed to ensure implementation of ICB priorities**	Membership of the Accountable Officer Group agreed. ToR for the Accountable Officer Group developed and agreed across partners. First meeting of the Accountable Officer Group held and forward plan agreed.	End Jan 2019 Feb 2019 March 2019	ICB ICB Carol Beckford	Completed. AOG ToR approved by ICB. ICB forward plan considered at AOG at in April. Complete

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
		Redraft the ICB ToR to reflect the relationship between the ICB, the AOG and the 'Transformation and Engagement Group'.	May 2019	Carol Beckford/ Alex Harris	
3.	**Identify SRO for the IC programme**	Agree SRO for the programme at first meeting of the Accountable Officer Group	March 2019	Accountable Officer Group	Completed. LBH CEO appointed as programme SRO.
4.	**Revise strategic objectives of the programme to allow a common narrative for the programme against which programme priorities can be set.**	ICB to agree the programme strategic objectives and programme outcomes. Develop a whole programme plan based on this with clear deliverables (including workstream plans etc.) Programme plan (including workstream plans) agreed by ICB.	Feb 2019 April - Sept 2019 ~~Sept 2019~~ November 2019	Carol Beckford Carol Beckford / Stella Okonkwo	ICB approved revised vision and strategic objectives. Complete Whole Programme Plane: Progress slow – as we need to ensure that we have Workstream and Enabler Group buy-in. We are going to use Planned Care as an exemplar to set out the approach and seek sign off from AOG before rolling out to all the Worksteams and Enablers
5.	**Ensure alignment of care workstream plans with IC strategic objectives and priorities.**	Workstreams to scope delivery plans for 19/20 and 20/21. Workstream plans approved as part of the overall programme plan by ICB.	April – Sept 2019 Sept 2019	Workstream directors and SROs	Workstream plans submitted in April as part of the NEL systems operating plan.

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
			October/November 2019		Workstreams plans will be refreshed as part of the long-term plan submission that will be approved by ICB in July Work has taken place to ensure alignment of Care Workstreams with the Long Term Plan and the IC Programme Outcomes Framework. The Summary Outcomes framework needs to be signed off by AOG – October/November
6.	**The ICB should seek assurance over, challenge progress within the programme and focus on strategic, transformational decisions (See Areas 1 and 2 above)**	Revise the ICB ToR to reflect focus on assurance and challenge and strategic decision-making. New ToR reflecting the relationship between ICB, the Transformation Group and Accountable Officer Group considered by ICB. Revised terms of reference for IC governance groups implemented.	May 2019 May 2019 June 2019	Carol Beckford/ Alex Harris Carol Beckford/ Alex Harris Carol Beckford	Scheduled for approval in June 2019. On track. Scheduled for approval in June 2019. Complete
7.	**Produce roadmap of decisions for coming years**	Roadmap developed and agreed by ICB.	~~May 2019~~ November 2019	Carol Beckford	Will be considered by AOG in June and ICB in July 2019. To be revisited in Sept 2019 by ICB. As 4 above

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
					In progress running late. Revised Target November 2019
8.	**Develop a new communications and engagement plan**	Draft communications strategy, implementation plan and IC logo produced. Communications strategy approved and implementation started. Suite of communication materials produced including presentations, leaflets etc.	End Jan 2019 End Feb 2019 March 2019 December 2019 December 2019	Ben Knowles	IC Communications Strategy signed off by ICB – September 2019 IC Strapline – signed off by ICB – September 2019 IC Logo not signed off by ICB. To be revisited no later than December 2019 Some work to be done to complete the Suite of communications materials e.g. Newsletter, IC Explainer Document, IC Website etc.
9.	**Ensure COI are addressed consistently throughout the IC governance structure**	Review the integrated commissioning programme CoI (Conflicts of Interest) Policy and re-issue if required.	March 2019 July 2019	Alex Harris	In progress. The policy is in line with good practice. Improvements in practice discussed with the workstream TSOs and the CCG Head of Corporate Services and will be implemented from May 2019. In progress.

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
		The ToR for all IC governance groups to include reference to the CoI policy. To be approved at July AOG.			Complete
10.	**Review meeting membership and frequency and ensure reports are focused and concise**	Develop a standard template for IC Board papers which specifies the requirement to be concise, which groups the report will be presented to, including the value each group is expected to provide. All governance groups to review membership and frequency of their meetings.	April 2019 April 2019	Alex Harris Chairs/SROs	In progress. Discussions with workstream directors have been held. Complete Complete
11.	**Performance measures for the programme to monitor progress against strategic objectives should continue to be developed and reported to the ICB**	Outcomes Framework for the programme and workstreams being developed including performance measures and metrics. Outcomes framework and measurements considered by ICB. Performance against programme outcomes framework reported to ICB twice a year and in workstream reports to ICB.	Jan 2019 Feb 2019 From July 2019 November/December 2019	Yashoda Patel Anna Garner	Initial report approved by ICB in February 2019 and further report at April AOG. Scheduled for July AOG and September ICB. Running late: Summary Outcomes Framework with performance to be presented to AOG October/November and ICB November/December 2019
12.	**Set annual transformation and**	ICB to set strategic programme-wide transformation objectives and business	April 2019	Carol Beckford	For October ICB.

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
	business as usual priorities for the programme (see Area 4 above)	as usual priorities for the programme annually. Workstreams to set their own priorities based on the ICB's priorities.	By May 2019	Workstream Directors	The Care Workstreams and Enablers have plans which include business as usual and transformation priorities. A decision has been made not to separate. Recommend remove this implementation action
13.	**Agree standard terms of reference for the workstreams (See Areas 1, 2 and 6 above)**	Draft workstream terms of reference. Draft workstream terms of reference considered by workstream boards. Workstream terms of reference approved by ICB.	February 2019 April 2019 May 2019	Alex Harris/ TSOs	Template developed and work is in progress. Delayed approval at AOG in May, due for approval by AOG in July. Approved by AOG Complete
14.	**Develop induction programme for new members of IC programme**	Programme developed and signed off. Induction programme in place.	April 2019 From May 2019	Olivia Katis	Draft completed. Will be considered by AOG in September, delayed from initial date of June. Complete
15.	**Review of risk sharing being undertaken including in relation to further pooling**	Review of risk sharing arrangements across partners as part of the work to move to a system financial control total. Revised risk sharing protocol approved by ICB.	~~March 2019~~ ~~July 2019~~ December 2019	CFOs	Discussions ongoing. Scheduled on ICB forward plan in October 2019. Work is underway looking at the future opportunities for Pooling. The

	Implementation areas	Actions	By when	Lead	Progress update (RAG rating)
					paper should be with ICB by December 2019

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DRAFT 2020 - 2021 City and Hackney System Intentions

Version 3 – 20/09/19

NHS City and Hackney Clinical Commissioning Group

NHS East London NHS Foundation Trust

City of London

City & Hackney GP Confederation
A community interest company

NHS Homerton University Hospital NHS Foundation Trust

Hackney

1. Introduction & Background

Scope

The move towards an Integrated Care System by 1 April 2021 sets a requirement within City & Hackney to migrate from "commissioning intentions" to "system intentions". This means working in partnership with our Providers to put in place integrated health and social care services which meet the needs of our changing population. Within City & Hackney, wherever possible we work in partnership with our Providers and have a co-production mind-set. Within this document City & Hackney's System Intentions are structure in line with the four care workstreams which deliver services within the local system, specifically: Unplanned Care, Planned Care, Prevention, Children, Young People, and Maternity & Families. Our major Providers and Partners within City & Hackney are:

City & Hackney's main Providers & Partners	
• Homerton University Foundation Trust	• London Borough of Hackney
• East London Foundation Trust	• City of London Corporation
• Barts Foundation Trust	• 3rd Sector Organisation / Community Providers
• North East London Foundation Trust	• London Ambulance Service
• University College Hospital Foundation Trust	• Private Sector Providers
• GP Confederation	• Healthwatch Hackney
• Healthwatch City of London	• Voluntary and Community Sector (VCS) / Hackney VCS

In drafting City & Hackney's 2020/21 system intentions, it is clear that the change to "system intentions" will be incremental. The roadmap for our system intentions mean that we will need to:

- Manage existing contracts to their contractual completion before we can transform them.
- Ensure that we have rigorous assurance processes in place to check that when new services are commissioned that we think innovatively regarding the range of Providers who can deliver health and social care services and how they might be delivered.
- Collaborate with existing and new Providers to co-design/co-produce new health and social care services which deliver on the goals set out in the NEL STP response to the Long Term Plan.

New contracts will have a particular, but not exclusive, focus on:

- Supporting the development of Primary Care Networks, neighbourhood and community services in order to transform these services for patients and the public.
- Taking an innovative approach to how we address long term conditions
- Supporting a step-change in our approach to prevention services for City & Hackney residents
- Creating seamless urgent care services which will complement our acute and primary care services

Our Mental Health System Intentions are integrated within each of the four care workstreams. In addition, we have drawn attention to our five Mental Health priorities and the associated services namely; prevention, access, neighbourhoods, personalisation and co-production and recovery.

Our process for developing and signing off our 2020/21 System Intentions

Our System Intentions were developed by:

- Inviting Care Workstream Directors to document the system intentions for their workstreams through discussion and engagement with Providers, Partners and Stakeholders within their respective workstreams;
- Ensuring that all four Care Workstream Boards sign-off on their individual 2020/21 System Intentions;
- Securing signoff to the integrated City & Hackney System Intentions from the City & Hackney Accountable Officers Group; and subsequently
- Securing signoff to the integrated City & Hackney Systems Intentions from the City & Hackney Integrated Commissioning Boards (which meet in common).

The remainder of this document sets out the narrative for City & Hackney's System Intentions.

Further details on our areas of work which will underpin our transformational services in 2019/2020 and 2020/21 can be found in the following annexed documents:

A. 2020 - 21 City and Hackney System Intentions partner specific changes
B. Draft City and Hackney 2020 - 21 System Intentions: Overview on a page

Planning for Contractual Change required by System Intentions

Many of the aims and objectives proposed in these System Intentions will require contractual interventions in order to be delivered. These will take the form of contract developments for the 20/21 contracts or Contract Variation in the 20/21 contract year. Examples of contractual interventions that may be required are specifying new or additional service developments, changes to the funding of existing or modified services, changes to existing service specifications, and decommissioning of all or part of existing services.

It is important therefore in the spirit of System Intentions that we work with providers in the appropriate contractual forums to identify what contractual intervention are required and plan to put these in place providing the required notice period where contractually this is required.

We need to be clear on the timeline for these changes. We will start planning for 20/21contracts in late September 2019 and it is anticipated that contracts are likely to be signed off early in January of 2020. Work Streams therefore need to initiate discussions with the Contracts team to forward plan these contractual changes as soon as the System Intentions are signed off.

2. Our Population

What is our population like?

We cover an area of North East London made up of the City of London and the London Borough of Hackney.

Despite significant economic growth and regeneration in recent years, City and Hackney faces significant health and wellbeing challenges. Hackney remains one of the most socioeconomically deprived boroughs in England and It is one of the most diverse areas in the country with nearly 90 languages spoken as a main language. (Hackney Borough Profile 2019).

The resident population of City and Hackney in 2018 was estimated at 289,400; the projected population will be 304,600 in 2023 – a growth rate of 5.3% over 5 years (Greater London Authority, 2016).

2.1 Hackney's population

Hackney's population is estimated at 281,700 people. The population is likely to grow to 299,500 people by 2028 and to 351,600 people by 2050 (Greater London Authority, 2016).

Hackney has a younger population than the rest of England, with a higher proportion younger working age adults such as those in their 20s and 30s (City and Hackney Public Health Team, 2018). The proportion of residents between 20-29 years has grown in the last ten years and now stands at just under 20%. People aged over 55 currently make up only 15% of the population. Those aged 65 and over are projected to contribute the most to population growth, with their numbers increasing rapidly in the next decade. This is likely to increase demand for health and social care services in the future.

Ethnicity

As well as a high working age population, Hackney has a high level of ethnic diversity, with 36.2% of the residents identifying as White British, followed by Other White (16.1%) and Black African communities (11.4%). A large and increasing group of residents come from mixed ethnic backgrounds, further increasing the diversity of the borough.

2.2 The City of London's population

The City of London resident population is 7,700 in 2018 (Greater London Authority, 2016) but 360,000 workers' influx daily - this figure is from 2014, it may be more now (The City of London, 2014). The resident population is projected to grow to 9,100 by 2028 and to 10,600 by 2050 – this growth is expected to apply to those aged 65 and over in particular.

The City of London has the highest daytime population of any local authority area in the UK, with hundreds of thousands of workers, residents, students and visitors packed into just over a square mile of densely developed space. The City of London also has the sixth highest number of rough sleepers in London.

Ethnicity

The City of London has a diverse range of ethnicities. An estimated 78% of the City of London population identify as white British; however, approximately 40% of children are from black or ethnic minority groups compared to 21% nationally. The City has relatively small resident population and a large number of service users commute into the area for work.

Across the Boroughs

Public Health in the London Borough of Hackney has a strong relationship with the City of London with a number of public health services commissioned in partnership.

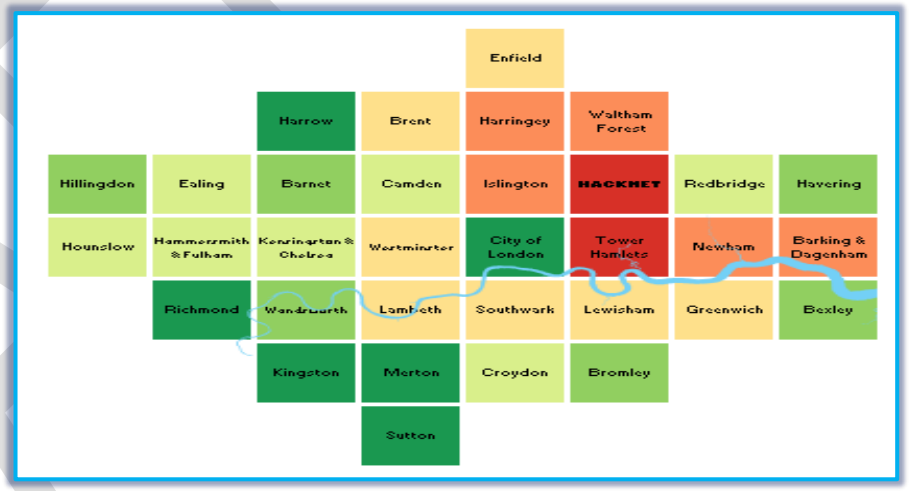
There is high population turnover in the City and Hackney, which can mean frequent new registrations for services. Additionally, ~ 25% of children in City and Hackney were classified as living in a low-income family (City and Hackney Public Health Team, 2015)

In 2017/18, 332,272 people were registered with an NHS City and Hackney CCG GP (City and Hackney CCG, 2018). Applying the resident's growth rate of 5.3%, the total registered population is estimated to be 349,882 in 2023.

The wider determinants

Understanding the sociodemographic profile of an area is important as different population groups have different health and social care needs and interact with services in different ways.

Hackney is the 2nd most deprived borough in London and 11th nationally (IMD2015). The City has lower overall deprivation but significant levels in the east. It is likely that Hackney's relative position will continue to improve overall (City and Hackney Public Health Team, 2015).



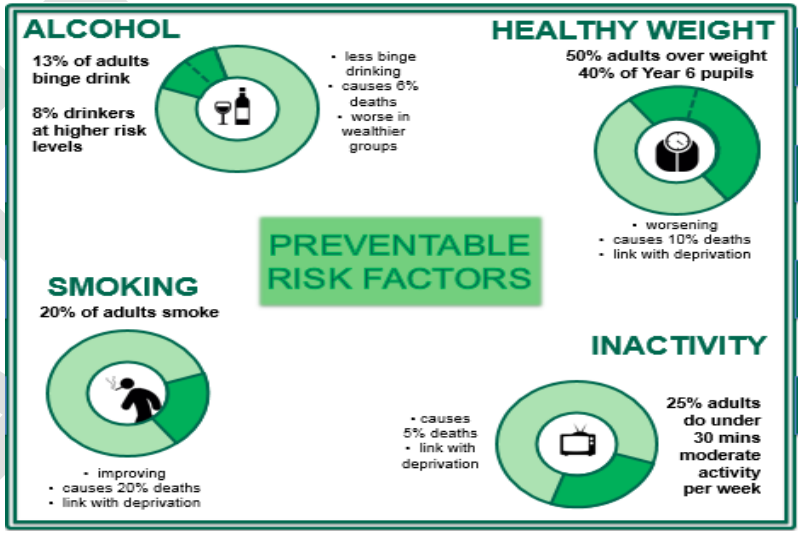
IMD 2015 the redder the square, the higher the deprivation

However, welfare reform impacts on Hackney are high due to deprivation, out of work and in work poverty. (City and Hackney Public Health Team, 2018)

A high proportion of Hackney's population are degree qualified and it has a similar unemployment rate to London. (City and Hackney Public Health Team, 2015) This may explain Hackney's lower than expected all-cause Years of Life Lost rates, given the high level of deprivation (Insitute for Health Metrics and Evaluation, 2018)

Evidence suggests that inequalities adversely affect health across all social strata. Social inequality is likely to increase locally, as wealthier residents move into the area (City and Hackney Public Health Team, 2015) *IMD 2015*

Risk factors



Behavioural

Around 35% of all deaths in Hackney residents are considered to be preventable, or amenable to healthcare – among the highest rates in London (City and Hackney Public Health Team, 2015)

Prevalence of excess drinking is higher in affluent groups, (City and Hackney Public Health Team, 2015) but harms from alcohol disproportionately affect those in deprived areas. (Alcohol Change UK, 2018). Tobacco control is a local health and wellbeing priority. (City and Hackney Public Health Team, 2018)

Clinical

Atrial fibrillation, hypertension and diabetes prevalence are lower in the NHS City and Hackney CCG than England average, much of this is likely explained by the younger population in the area.

3. Communicating & Engaging with our Population

Introduction and context

Each year, NHS Clinical Commissioning Groups (CCGs) are expected to provide opportunities for local members of the public to view and comment on their draft commissioning intentions (CIs) for the year ahead. As opposed to a single commissioning intentions event, the approach for seeking engagement into the 2019/20 and 20/21 Integrated Commissioning System Intentions has been to run a rolling programme of engagement events providing on-going feedback, which care workstreams consider and act upon.

In addition to the above, differences compared to previous years include covering a 2-year commissioning cycle and aligning local intentions with the NHS Long-term Plan and the wider North East London footprint. Therefore, community insights that were gathered through commissioning intentions engagement in the autumn of 2018/19 underpin our local Long-term Plan submission later in the autumn and vice versa – the feedback we have received through our Long-term Plan engagement during this spring informs our review of the 20/21 commissioning intentions. Due to this overlap, we refer to the Long-term Plan/Commissioning Intentions (LTP/CI) in the information below. The time frame, for the purposes of this summary, is October 2018 to the present day.

How we've engaged with local residents

Delivered in partnership with local Health watch branches and communications and engagement colleagues across the Integrated Care System (ICS), engagement activity has been co-produced with user voice groups such as NHS Community Voice, the Hackney Refugee and Migrant Forum, and the Mental Health Advocacy Project as well as relevant care workstreams and representatives.

The approach to LTP/CI engagement in City and Hackney has made use of existing engagement structures and the IC's 'Let's Talk' brand has been used as the umbrella term for all events and meetings. Engagement topics have reflected the Integrated Commissioning Strategic Priorities, the co-produced Priority Themes (designed with input from residents), and key themes of the NHS Long-term Plan.

As of today, 23 events, 3 surveys, 2 focus groups, and a small number of 1-to-1 interviews have taken place across City and Hackney, enabling more than 1,200 residents to have their say on what they'd like local health and care services to look like in the future.

What people have told us so far?

An initial analysis of the emerging themes evolves around concerns about the future of the NHS, the importance of considering the wider determinants of health, the pros, cons and fears around digitalisation and the provision of a holistic, patient-centred care that considers the physical, social, and mental wellbeing of an individual's health, and is delivered locally.

People have told us that they value:

- Our local services but are worried about changes, closures, cuts and the fact that the 'Limited resources' narrative features frequently
- Bringing services back to City and Hackney (e.g. placements for children in care, elderly residents based out of the borough);
- Our long term plans and see as an opportunity, but also as a threat (e.g. privatisation, dismantling of the NHS)
- And are willing to embrace new technologies, but not at the expense of face-to-face appointments with their GP. On the one hand, people want health services to be able to share information and help wrap care around the patient, but on the other hand, they are worried about data protection issues
- A well-co-ordinated and safe out-of-hours services.
- Services that can support people in the community after they are discharged from hospital or specialist care and the role of community and voluntary sector in providing this support.
- Good mental health support for young people, new parents, and the working age population.

'You Said – We Did'

The feedback on 'You said – We did' is collected and this information fed back into the CCG and used to inform the work we do, including defining our commissioning Intentions and improving services. Here are some examples of what people have told us and the actions we have taken.

The feedback documents are also available on the CCG's website **http://www.cityandhackneyccg.nhs.uk/about-us/you-said-we-did.htm**

YOU SAID	WE HAVE (Actions already taken)	WE WILL (Priority actions we plan to take in our Local Strategic Delivery Plan for the City and Hackney System)
Mental health support for young people, new parents and working age population needs to be improved	• Children and Young People have access to the Well-being and Mental Health in Schools (WAMHS) project, First Steps Tier 2 service, and the Five to Thrive (five ways to well-being) initiatives in schools. • Our CAMHS transformation plan includes LGBT work and self-harm follow up in Family Action and Transition work with Off Centre. • We have a two-week accelerated referral process to the Talk Therapies service for pregnant women and their partners. • We have developed 10 Top Tips to support mothers.	• We will improve care co-ordination for young vulnerable people, through implementation of an electronic care planning tool and through the use of digital passports. • We will improve access to a range of therapies for young people. • We will expand ongoing support for people with severe mental illness and complex needs in primary care.

YOU SAID	WE HAVE (Actions already taken)	WE WILL (Priority actions we plan to take in our Local Strategic Delivery Plan for the City and Hackney System)
There is a willingness to embrace new technologies, but not at the expense of face-to-face appointments with their GP. People want health services to share information to help wrap care around the patient but are worried about data protection issues	• The City and Hackney system makes considerable use of Co-ordinate My Care (CMC) beyond its main use for end-of-life care planning, to co-ordinate shared urgent care for patients with dementia, patients on Proactive Care Registers, and nursing home patients. • The Homerton has begun using widespread text messaging of reminders for appointments and is considering IT solutions as alternatives for communication with patients.	• We will continue to make use of telehealth and virtual appointments as part of our Outpatients Transformation Programme.
Access to community based, non-clinical services with a holistic approach is important.	• Our social prescribing service operates in every GP practice in City and Hackney and is working with PCNs to integrate new provision including peer support and group consultation. • We are also developing an IC approach to Speech and Language Therapy. Services will be delivered in a more Integrated way by pooling budgets and creating a programme that can be delivered by one Provider.	• We will continue to pilot work on multi-agency working and holistic models of care through the Neighbourhoods programme.

YOU SAID	WE HAVE (Actions already taken)	WE WILL (Priority actions we plan to take in our Local Strategic Delivery Plan for the City and Hackney System)
Well-co-ordinated and safe out-of-hours services are needed.	• We have developed a wide range of care to keep people out of hospital; these rapid response pathways include step-up care within the re-ablement team (IIT), the Paradoc service, and the Duty Doctor (where a practice-based doctor is always available to see or speak to patients urgently to avoid a hospital visit).	• We will implement an Urgent Treatment Centre (UTC) model so all localities have the same out-of-hospital urgent care provision, with the option of calling the NHS on 111. UTCs will work alongside the urgent care network including primary care, community pharmacists, ambulance services and other community-based services to provide local accessible and convenient choices to help avoid A&E visits.

4. Our local strategic delivery plans

Our local strategic delivery plan and NHS Long Term Plan response

In City and Hackney, we believe that all our residents deserve to live the healthiest and most fulfilled lives possible. Local people and their families want to feel connected to their neighbourhoods, to access high quality care near their homes and in hospital when they need to. Since 2016, we have been working with other organisations who deliver and commission care in City and Hackney to provide better and more joined up services for City and Hackney's residents.

Our local strategic delivery plan is being developed to meet the health and wellbeing needs of local people by delivering the NHS Long Term Plan, and focusing in particular on our local vision and priorities for the necessary large-scale transformation of services over the next ten years. In City and Hackney, our strategic programmes integrate and personalise patient care, empower patients to manage their own health, and provide care which is close to where patients live and work - some of the key initiatives of the Long Term Plan.

Our local system plans include many examples of our commitment to improve quality and harness innovation, and we aim to be innovative too in the way we foster collaboration and integrated working amongst clinicians and partners from different organisations. The main themes of our long term plan and the priorities identified in the NHS long term response include:

- ***Transforming out-of-hospital care and fully integrating community care*:** Through the Neighbourhood Health and Care Services Programme we aim to transform and integrate the provision of out-of-hospital services, informed by whole system workshops held in January 2019.
- ***Reducing pressure on emergency hospital services*:** A really joined-up and integrated local urgent care system: Commissioner and Provider system partners in City and Hackney are working together to deliver an integrated urgent care pathway. This will meet people's urgent care needs, triage and navigate them to the most appropriate place at every entry point into the system, and support people away from the hospital wherever it is appropriate to do so

- ***Digitally enabling primary care and outpatient care***: The City and Hackney system makes considerable use of Co-ordinate My Care (CMC) beyond its primary use for end-of-life care planning, to co-ordinate shared urgent care for patients with dementia, patients on the Proactive Care Registers, and nursing home patients. Due to our local system expertise, City and Hackney represents North East London in the development of CMC at a London level.

  The City and Hackney Directory of Services project will provide a key resource to support more integrated health and wellbeing services in the local system and ensure that care navigation, social prescribing and other interventions are better co-ordinated and supported locally. Work is underway in a number of priority specialties to make use of telehealth and virtual appointments within the Outpatients Transformation Programme. Priority specialties where projects are already underway include diabetes and dermatology.
- ***Giving people more personalised care and control over their own health***: Across services which meet the health, care and wellbeing needs of patients, we have been working to champion strengths-based, person-centred models of care. In our Prevention Workstream we are working closely with our local authority partners and with health and care services. Through a number of programmes, we are implementing training for front line staff in motivational interviewing and other interventions to support and increase patient activation, self-management and choice.
- ***An increasing focus on population health and moving to an ICS approach:*** In September 2019 the Neighbourhoods Programme will take a decision on our approach to population health management tools, including risk stratification and case finding, based on an options appraisal of existing tools and their likely readiness to support integrated care in Neighbourhoods. We continue to work with STP partners on the development of system-wide approaches.

5. Integrated Commissioning Board (ICB) Plans for 2020/21

In-line with our Long term plan, The City and Hackney System intention is focussed on a City and Hackney cross-system planning; Bringing Providers together to better deliver outcomes for our population and as work continues across the system, our aim is to see even closer, more collaborative working between the CCG, Healthcare Providers, Local Authorities and Social Care Providers.

Within our existing contractual relationships, we are already seeking considerable innovation, and will look to extend the identification of cohorts of patients against which we can focus new approaches and means of reducing unwarranted clinical variation wherever possible. As the North East London Commissioning Alliance continues to develop and emerge, this too will influence commissioning activity in the years ahead.

Further details on how we will work as part of an integrated system through our Care Workstreams with our Providers and Partners to deliver these services can be found at the annexed documents.

5.1 The Unplanned Care Workstream

Overall

The unplanned care workstream is part of the integrated care system in City and Hackney. The over-arching workstream objective is to bring together partners to create services that meet people's urgent needs and support them to stay well. This document describes the workstream's objectives which contribute to achievement of the City and Hackney system outcomes.

In order to achieve this, we will deliver the following strategic priorities:

- We will develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- We will provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information

- We will develop urgent care services that provide holistic, consistent, care and support people until they are settled
- We will work together to prevent avoidable emergency attendances and admissions to hospital
- We will provide timely access to urgent care services when needed, including at discharge
- We will deliver models of care that support sustainability for the City and Hackney health and care system.

The workstream has three main transformation areas through which we are delivering these priorities; **neighbourhoods**, **integrated urgent care** and **discharge**, it also has responsibility for end of life care and dementia.

The following describes what we intend to deliver in 2021:

Neighbourhoods

The neighbourhoods programme is a cross cutting system wide transformation that sits across the workstreams. The areas of neighbourhoods' development that will be driven by the unplanned care workstream are as follows:

- Working with the primary care enabler to support the development of PCNs; recognising that PCNs are the fundamental primary care building block of each neighbourhood
- Ongoing transformation of community health and care services to deliver neighbourhood services. Priorities for transformation are: adult community nursing, adult community therapies, adult social care, community mental health services, and dementia.
- Implementation of an anticipatory care service, which will build on the proactive care services in primary care and will also include wider community partners.
- Working with voluntary sector and borough partners to ensure that neighbourhoods provide the platform for addressing the wider determinants of health through a place based approach. This includes working with prevention workstream to implement an effective model of navigation.

Integrated Urgent Care

We will progress our vision to deliver a joined up urgent care system that quickly navigates people to the right care setting and manages people away from the hospital wherever it is appropriate to do so.

Specific areas of work are:

- Ensuring a direct referral route from 111 and/or 999 into all of our community based rapid response services including Paradoc, Integrated Independence Team (IIT) and Duty Doctor. We will work with LAS to increase uptake of these services.
- Work with the Homerton to continue to realise benefits from being the single Provider for both the Primary Urgent Care Centre and GP Out of hours' services.
- We will work with the mental health co-ordinating committee to review the new High Intensity Users services in order to inform the service model going forward.
- Implementing a sustainable model of streaming and re-direction at the hospital front door (for Barts and Homerton)
- Delivering strong Same Day Emergency Care pathways at the Homerton to reduce the need for admission where possible
- Working with LAS and North East London partners to identify and maximise all opportunities to reduce ambulance conveyances through a strengthened clinical assessment service and closer working between 999 and 111.
- Working with partners across Inner North East London (INEL) to scope the potential benefit for cross-borough provision of primary care out of hours' home visiting services
- Work with partners to continue to realise benefits from effective use of Co-ordinate My Care
- Working closely with our residents to understand what drives peoples use of different urgent care services, and, based on this, delivery of more informed and sophisticated communications to residents. We will work with INEL colleagues to consider where wider public messaging could have more impact.
- Progressing our falls programme, which encompasses both our acute response to falls and working with prevention workstream on falls prevention.
- Working with the planned care and prevention workstreams to develop and improve our respiratory pathways and services

Discharge

We will continue to improve discharge for our residents, ensuring that they can access the community services that they need and ensuring that they do not stay in an acute or mental health bed for longer than is medically required.

Specific areas of work are:

- Work with partners to ensure that our re-ablement and complex discharge teams based in the Homerton are as effective as possible. This includes ensuring that the complex discharge team and IIT work together closely and delivering a sustainable discharge to assess model.
- Identify the specific requirement of homeless people and rough sleepers both during their inpatient stay and at the point of discharge. Work with partners to improve this pathway.
- Continue to deliver effective primary care services to our nursing home residents, and consider whether the new PCN contract provides an opportunity to strengthen this.
- Work with our nursing homes to improve the interface with acute trusts by scoping delivery of a trusted assessor model and the 'red bag' scheme.

End of Life Care

- Sustainable delivery of an urgent end of life care service that supports people to die in their usual place of residence
- Ensuring that our range of end of life services are well connected to our urgent care services so that people receive continuity of care 24/7 and regardless of their access point into the urgent care system.

Dementia

- We will embed the Community Dementia service within the neighbourhood framework and we will work with the Dementia alliance to review the new dementia service in order to inform the service model going forward.

5.2 The Planned Care Workstream

With our partners: Homerton Hospital, East London Foundation Trust, London Borough of Hackney, City of London Corporation, City & Hackney GP Confederation, City & Hackney Community and Voluntary Sector

This document sets out a number of priority areas for service redesign and transformation within the "place based system" for City & Hackney, led by the planned care workstream. It should be read in conjunction with the Planned Care workstream plan on a page and the detailed system intentions developed by workstream team members, including system partners, clinicians and patient representatives. The programme of work has been in development since the workstream inception and has been refined and reviewed for 2020/21 in line with the NHS long-term plan and local developments with our colleagues in the other workstreams: Prevention, Unplanned Care and Maternity, Children, Young People and Families.

The most significant development during 2019 is the plan for a N**eighbourhood Health and Care (NHC) Service** within City and Hackney as the fundamental approach to "out of hospital" services. This Service will alliance provide the framework for a whole range of community services to be transformed to offer integrated, personalised care and support to local residents within the neighbourhood arrangements.

This provides an opportunity for the Planned Care workstream to go further with its **outpatient transformation** programme. We have been transforming the patient journey to outpatient care, reducing unnecessary follow-ups, building on the use of advice and guidance to support primary care and focus the role of secondary care services on those most in need of specialist support. We have already introduced a new virtual fracture clinic, tele-dermatology service and developed a model for increased community gynaecology capacity at the **neighbourhood/primary care network.** We have also increased links to psychological services for people with physical health problems though we can now have, with the NHC services alliance, much greater integration of physical and mental health care in our service models.

In 2020/21 we want to work with our partners in the alliance to build on these developments to redesign our community services to provide increased support within a multidisciplinary context for people with long term conditions. This model will combine psychosocial and medical approaches as well as ensuring links to access to community and voluntary sector services. These services will be an alternative to traditional

models of outpatient care; will focus on delivering a proactive and preventative service to people with **long-term conditions such as respiratory disease, diabetes, chronic kidney disease and dialysis** and be delivered closer to people at the neighbourhood/network level. Work on the use of **anti - coagulants** led by our prescribing team will also support early diagnosis and treatment of people at risk of atrial fibrillation and or a stroke.

We will also, through our NHC services alliance and integrated model, design services that provide a holistic and combined offer that is not limited in scope by funding or contracting arrangements. Our initial proposal is to develop a **women's health service** where we will design a model of care that integrates contraception services, sexual health and gynaecology with women's physiotherapy, mental health and wellbeing services.

Other benefits for our residents are that the new community services will be responsive and will simplify the patient journey either by the use of **digital technology** or by services coming together to reduce the duplication of time and effort for both for the patient and for professionals.

We will also work with our partners to strengthen the **personalisation** of our services and embed approaches to ensure that our residents are **in control of their care, supported to make informed choices and decisions,** provide digital tools to aide **self- management for** people with a long-term condition and **provide the choice of a personal** budget if preferred. People with long term mental health problems will also have access to digital tools to support self-management and will be have access to a personal health budget when appropriate.

Other priorities for people with long term conditions are to redesign **the rehabilitation and recovery pathway for people who have had a stroke** to support people to maximise their independence, are supported to return to work where possible as well access specialist services through the NHC services alliance. Our focus for people with **cancer** will be to ensure that people are **diagnosed early** by their GP and treated promptly on the **62- day cancer treatment pathway.** We will also work with partners in primary and secondary care in implementing the **Faster Diagnosis Standard** by April 2020**.** We will continue our work to **improve screening uptake for bowel cancer** particularly within vulnerable communities and provide more community support for **people in recovery** from cancer treatment.

We have developed a **strategy for all people with learning disabilities**, which we will implement from 2020. The strategy aims to strengthen our approach to personalised services promoting independence, maximising opportunities to meaningful activities, **employment and access to mainstream services** and providing care closer to home where ever possible. We will aim to offer a specific personal budget approach to people with learning disability in support of the new strategy. We are working with the Children and Young People's workstream to strengthen our **Care and Treatment Reviews** and interventions for children and young people with a learning disability or autism. We are also ensuring that our provision of **physical health checks** and action plans for people with a learning disability in primary care is widely available and fully implemented. We would also ask the support of health and social care partners in **making reasonable adjustments** within their mainstream services so that people with learning disabilities and autism are able to access them.

We will continue to support improvements in care for people at home through our transformation plans for the delivery of **Continuing Healthcare (CHC)** which we are working on with our partners in North East London. We will maintain our local focus to support the core neighbourhood team in delivery of CHC and on meeting the national requirements for waiting time to **completion of assessment within 28 days and assessment in the community as opposed to a hospital setting.**

With our local authority partners, we continue to develop protocols for joint funding of care packages and strategic planning for **local nursing home provision**. We are also working on the development of specialist skills and increased capacity in specialist pathways such as mental health and neuro-disability.

5.3 The Prevention Care Workstream

General

We will continue to commission high quality prevention services to achieve our three core (and overlapping) aims to:

- Reduce the harms from the main preventable causes of poor health
- Take early action to avoid or delay future poor health
- Support and enable people to take control of their own physical and mental wellbeing.

We will continue with our work to create an enabling environment to embed prevention across the local health and care system, including through our 'making every contact count' programme and joint work with partners to develop a neighbourhood community navigation model (including a re-modelled Social Prescribing service).

Making every contact count

We intend to embed MECC principles in health and care service provision through appropriate contractual levers, to support the sustainability of our approach to system-wide action on prevention.

Supporting people to take control of their own health and wellbeing

- We will re-commission the existing Social Prescribing service to integrate fully with new PCN provision (funded SP link workers) and align with the new Neighbourhood care navigation model as it emerges.
- We will use the learning from two digital pilot projects (Digital Social Prescribing Platform and Directory of Services) to improve access to, and awareness of, local prevention services.
- We will use the learning from the 'three conversations' innovation site to embed a strengths-based, preventative approach across social care practice in Hackney.

Long-term conditions (LTCs) - earlier intervention

Primary care in City and Hackney has an excellent track record in identifying and managing patients who are at increased risk, or living with, a

range of long-term conditions. However, premature mortality from preventable conditions (including cardiovascular and respiratory disease) remains higher than average locally, and there is more we can do to tackle inequalities through a more comprehensive preventative approach.

- We intend to start work to refocus the LTC contract with the GP Confederation to have a stronger emphasis on incentivising prevention.
- We will review current indicators in the contract, with potential to include/enhance incentives for: alcohol screening and brief advice; reducing variation in referral rates to stop smoking services; COPD and asthma prevalence/case finding; group consultations and self-management; identifying and improving access to support for carers (including linking in to new carer support services in Hackney and the City); implementing annual reviews for other conditions (epilepsy, sickle cell); amongst other things.
- We will also integrate the NHS Health Check contract (also delivered by the GP Confederation) with the LTC contract to optimise and align incentives for CVD prevention in primary care.

Obesity

Collaborative working to tackle obesity locally will continue through a new 10 year strategic 'healthy weight' framework, which has been co-produced with a broad alliance of partners. Providing easy access to targeted support for people at greatest risk of obesity-related harm is one of five shared priorities in the new framework. This reflects priorities within the NHS LTP to take action to improve access to weight management support for adults and children with complex needs/co-morbidities.

- Working with the Planned Care Workstream, we intend to commission a new weight management service to meet the needs of people with complex needs who are not eligible/suitable for bariatric surgery. In designing this service, we will incorporate learning from the Homerton Diabetes Service 'very low calorie diet' pilot.
- We will review current provision of 'lifestyle' weight management services (for adults with less complex needs) and work with partners to develop an integrated adult obesity pathway.
- Working with the CYPMF Workstream, we will undertake a review of the child obesity pathway, with a focus on designing services to meet the needs of children and young people with complex needs who are not eligible/suitable for existing lifestyle weight management

services.

Tobacco

Tackling tobacco dependency within the NHS is a key priority, both nationally and locally. The NHS LTP sets out an ambitious plan to offer all people admitted to hospital NHS-funded tobacco treatment services (through the 'Ottawa' model of bedside support to quit), and a universal smoking cessation offer for long-term specialist mental health service users.

- We intend to embed tobacco screening and brief advice targets as service KPIs from 2020/21, building on progress made by measures put in place by both Homerton and ELFT through the alcohol and tobacco screening and brief advice CQUINs.
- We will collaborate with NEL partners, working in partnership with Homerton and ELFT, to develop a business case to implement the Ottawa model locally.

Alcohol and substance misuse

Whole system action to identify, and take early action to prevent, harmful alcohol use is a key workstream priority, supporting delivery of the new alcohol strategies for Hackney and the City. There are significant opportunities for early intervention in the NHS to reduce alcohol-related harm.

- We intend to embed alcohol screening and brief advice targets as service KPIs from 2020/21, building on progress made by measures put in place by both Homerton and ELFT through the alcohol and tobacco screening and brief advice CQUINs.
- We will complete the re-procurement of a new integrated City and Hackney adult substance misuse service, incorporating service model improvements to better meet the diverse needs of people with alcohol as well as substance misuse, and improve access to mental health support.

Sexual health

- We intend to work with the Planned Care Workstream to develop a collaborative approach to commissioning women's sexual and

reproductive health.

Mental health

Preventing poor mental health and promoting positive mental wellbeing remains a core objective of the Prevention Workstream, with the new Joint Mental Health Strategy setting out our ambitions and how we will achieve these.

- We intend to design a new service offer to better support a targeted preventative approach, informed by the new City and Hackney Mental Health Strategy and the findings of an evaluation of the Wellbeing Network.
- We will continue to work with local VCSE and statutory providers to improve the offer of supported employment provision for people with mental illness, learning disabilities and other support needs.

Learning disability and prevention

We will work with Planned Care colleagues to implement actions on prevention as set out in the new City and Hackney Learning Disability Strategy, in particular:

- To develop approaches to embed 'reasonable adjustments' in mainstream prevention services so they are accessible to people with LD. This is a cross-workstream priority.

Rough sleepers

- We will use the learning from various local pilots currently underway/planned to inform the development of effective care pathways for rough sleepers in Hackney and the City.

5.4 The Children, Young People, Maternity and Families (CYPMF) Care Workstream

We will continue to work to give our children and families the 'Best start in life' (LTP 2019) by commissioning high quality services, that maximise health and wellbeing outcomes for families throughout the early part of the life course. Alongside delivering quality improvements in our key business areas, we will continue to focus on the transformation of:

1. Emotional health and wellbeing (mental health)
2. The health of our most 'at risk' or vulnerable groups
3. The offer of care throughout maternity and the first 1000 days

We will continue to implement the transformation outlined in the NHS Long Term Plan, particularly across Maternity, CAMHS, and improving our care for children with Learning Disabilities and Autism. We will explore how we can improve access, experience of services and outcomes through use of digital technologies, strengthening prevention and working at scale across with our North East London neighbours (NEL STP) where this gives us the best return.

Specifically, for 2020/21 we will build on the opportunities to strengthen relationships through our integrated care partnerships and more locally, through our multi-agency work at Primary Care Network level.

Maternity

In line with the national maternity transformation outlined in the Long Term Plan, and with our partners across the East London Local Maternity System, we will continue to focus on **quality improvements in service delivery**, building on the improvement trajectory and recent CQC inspection recommendations (August 2018), working toward an 'Outstanding' rating (now 'Good').

Also in line with the LTP aim to accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025 we will continue to roll out the '***Saving Babies Lives Care Bundle'*** and continue to maintain our focus on reducing infant

mortality and avoidable admissions to NICU. This includes being part of the National Maternal and Neonatal Health Safety Collaborative and having a named Maternity Safety Champion.

We will build on our strong trajectory in **continuity of carer implementation**, through the HUFT CQUIN for diabetic women and more generally so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.

We will continue to promote the offer of the **flu vaccination and pertussis** for expectant mothers, as part of the wider City and Hackney 'Improving uptake of immunisations partnership action plan'.

One of our Long Term Plan commitments is to improve access to and the **quality of perinatal mental health care** for mothers, their partners and children by increasing access to evidence-based support. A perinatal mental health offer is in place for women with moderate to severe mental health concerns in the City and Hackney system, as part of work at STP level. City and Hackney have expanded their perinatal service in line with the 2019-20 targets.

We want to agree clear long-term pathways to support women to **access OTC and prescription medicines** throughout the antenatal and post-natal periods, working with Primary Care and Pharmacy.

We will continue to work through Primary Care and our VCS partners to ensure there is **focussed early support**, and a clear pathway for our most **vulnerable women in their pregnancies**, through enhanced checks and education.

We will work toward implementing **digital solutions to support working better** with patients, including maternity digital care records, digital child health information ('e-red book') records, and development of an app to support pregnant women to navigate our services.

We will work closely with our service users through our Maternity Voices Partnership, and wider mechanisms to focus on **improving women's experiences of maternity care.** This includes work with Primary Care around promoting choice.

We will also support **development of care through the neo natal period**, in line with our NICU and would like to strengthen our community offer through HUFT

With the Prevention workstream, we will continue to focus on implementing the **new smoking in pregnancy pathway**, and support the development of the MECC programme, through piloting in the maternity service. We will also begin to scope the need and development of complex obesity pathways for maternity and CYP. This work will be linked to the development of the adult's complex obesity pathway, which is already in development

Children and Young People

In line with the new national Children and Young People's transformation outlined in the LTP, we will continue to deliver on our comprehensive integrated developments locally through:

- Continuing to develop and embed partnership arrangements to deliver **Transforming Care** and preventing the avoidable admission of **CYP with autism and / or LD** who display challenging behaviour to specialist inpatient hospitals. We will strengthen the system wide approach to identification, joint working and monitoring of this cohort, including implementing clear processes for delivery of CTERs (Care, Treatment and Education reviews), across the system. This work links closely with Planned care adult LD and Transforming care work.
- Developing and implementing a system wide approach to raising awareness and reducing the impact of **Adverse Childhood Events**, incorporating three separate workstreams that strengthen workforce, improve the offer of early support and parenting, and develop a digital resource portal to support professionals and carers. As part of this we will consider the development of Adverse Childhood Events education and awareness in primary care, secondary care and in universal services (schools and early year's settings).

With health, education and social care partners, we will review the total **Speech and Language Therapy** budget against the level of need across City and Hackney, including reviewing the CCG and health contribution to the Youth Justice budget (for SaLT). We will develop an

integrated commissioning framework and service model for CYP SaLT provision in City and Hackney, underpinned by pooled budgets between CHCCG, Hackney Council, City of London Corporation and other funding sources.

We will initiate a similar joint review for **Occupational Therapy**, and explore reviewing the commissioning of Learning Disability across the partnership. This is in line with STP priorities around reviewing therapies.

To **improve the Health of looked after children** and care leavers, we will implement an integrated service model for the health assessment, caseload management and nursing provision for looked after children placed by / in City and Hackney, and a comprehensive health offer for care leavers up to the age of 25. We will continue to monitor and evidence the impact of the newly commissioned Health of LAC service model delivering a case management approach with enhanced oversight.

Commissioning a sickle cell mentoring scheme across the STP

With Primary Care, we will recommission **the Early Years' service** recognising the reduction in available funding, and work to develop the coding of CYP with complex needs and including autism, ASD, and LD.

Linked to our wider City and Hackney Immunisations Plan (see above), we will continue to work with the GPC and system partners to **improve childhood immunisation coverage** and childhood flu, utilizing the developing neighbourhood and Primary Care network structures.

We will continue to review the opportunity to **integrate our VCS KIDS and Huddleston short breaks services** with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme

With the Homerton University Hospital Trust, we will implement recommendations arising from the review of lead professional and key working roles for children with complex needs, in line with the LTP recommendations and continue the development of monitoring and review processes to **support the delivery of SEND requirements**.

We will also review the impact of the community paediatricians to the **audiology** Tier 2 service, and mobilise the reconfigured child health clinics across agreed general practices.

With the Unplanned Care workstream, and in line with the STP, we will explore patterns in **A&E and urgent care attendance** by under 25 year olds, and look at how we might implement learning from successful reduction strategies in adult services.

In line with LTP recommendations we will continue to monitor the new local **paediatric critical care tariff** implementation, and ensure additional support for training is delivered.

In delivering our new safeguarding responsibilities, we will continue to work with partners to **implement the 'Working Together' guidance**, putting in place the new statutory NEL child death review transformation plan. By 29th September 2019 we will ensure that the new operational processes are delivering for City and Hackney, working closely with HUFT to embed these.

Work is beginning to explore the possibility of joining the **0 - 25's** public health, community nursing services (health vising, family nurse partnership, school based health and CHYPS Plus) into one commissioned service. A joint service would likely be commissioned to start in the 2021/22 financial year. For 2020/21, we will continue to commission our strong Health Visiting, School Based health (school nursing) and Family Nurse Partnership services.

Linked to the Prevention work, our **CYP physical activity services** are being redesigned and aligned to other physical activity services in the Council. It is anticipated that the new physical activity services will be commissioned to start in April 2020.

Also linked to Prevention, our Young Hackney **Substance Misuse** Service: The current SLA expires in October 2020, in line with the adult's substance misuse service. As part of the scoping for the design of both the adults and CYP substance misuse services, it was decided that the adults and CYP service would remain separate. The CYP service will be redesigned and commissioned over the next year.

Child and Adolescent Mental Health

Building on a comprehensive CAMHS offer for our Children and Young People, and a robust transformation plan, we will continue to ensure we are implementing the LTP recommendations for improving mental health up to the age of 25, by focussing on:

Development of 24/7 Crisis pathway for CYP and agreeing models for delivery. We will explore options to expand deliver a 24/7 CYP Crisis by expanding the age range of adult services through embedded specialists and training in line with the Gloucester model. The delivery of a 24/7 crisis pathway may also involve collaboration with other CCGs and will be aligned to New Models of Care. Funding is expected to come from NHSE Tier 4 beds savings. In order to commission this, we require information about new models of care and specialised commissioning savings delivered to ELFT.

Eating Disorders: we want to ensure we exceed the national eating Disorders Waiting time and Access targets

Creating **a single point of access** and a work **toward a fully integrated Tier 3 CAMHS service** (including CAMHS disability services) working as a single integrated team.

Developing a comprehensive **18-25 Transitions service** (Tier 2 and Tier 3) in line with national requirements

Developing an **improved offer for the mental health of very young** children (0-5) and their parents which incorporates work from the ACEs project team.

Continuing to roll out our **Wellbeing and Mental health in schools' work** (WAMHS) to all state maintained schools and develop a similar offer to state registered Independent schools that have a majority City and Hackney population. This will be supported by the development of NHSE funded **Mental Health in Schools Teams** from September 2019.

Achieving **viable MHSDS outcome reporting** that reflect accurately the work being done

Clinical Pathway Optimisation: based on the up and coming Demand Vs Capacity review of all our CAMHS pathways work collaboratively to deliver the output / recommendations.

Reviewing our **Youth Justice Pathway Early Help and Diversion pathways,** with our partners across the system

We want to maximise our **digital capability** through implementation of an integrated patient journey management system across CAMHS services. This will include Investment in analytics support to CAMHS and investment in the development of the CAMHs website to support patients and their families.

With our VCS partners, we have secured funding to deliver work to **improve the mental health of Black African and Caribbean heritage young people** at key transition points. We will be supporting our partners to deliver this from late 2019.

5.5 An overview of City and Hackney 2020/21 Mental Health System Intentions

General

The overarching mental health strategy is contained in the draft joint mental health strategy document which has been jointly written by CCG, local authorities, ELFT, VCSE and service user representatives due to be signed of in October 2019. The strategy makes a commitment to 'develop a whole system, all-age approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners'. Our strategic priorities are set out in the table below.

Our five strategic priorities:				
Prevention: *We will prevent people from developing mental health problems in the first place, and provide help at the earliest opportunity when they do.*	Access: *We will improve access to mental health support and services, to reflect the diversity of our communities, the most vulnerable and those whose mental health problems are masked by other needs*	Neighbourhood *We will aim to support people in the community wherever we can, working at 'neighbourhood' level with schools, GPs and voluntary and community services.*	Personalisation and co-production: *We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services.*	Recovery: *We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks.*

These priorities are aligned to the NHS Long Term Plan (2019) and strategy commits us to achieving *NHS Long Term Plan* aims for mental health including the following key areas:

- *The 'new models of integrated primary and community care for people with SMI, including dedicated provision for groups with specific needs (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis)'* will be

principally achieved through the NHSE funded mental health Community Transformation Programme which will create mental health teams in each PCN/Neighbourhood.

- *Personalised care,* will be improved principally through the increase use individualised digital support including online therapies, care planning, navigation and booking; Personal Health Budgets and our commitment to co-produced care planning.

- *Reduced A&E use and admission by people with SMI* with 'complementary crisis alternatives' will be achieved through our continued use of open access crisis services such as the SUN project and the Crisis café and the High Intensity Service User service (HIUS)

- *Children and Young People* with a focus on the Green Paper *Transforming Children and Young People's Mental Health* (2017), will be achieved through our CAMHS Transformation Plan which creates an enhanced role for schools and a comprehensive offer for 0-25-year olds to support transition to adulthood.

Integrated Care

We will continue to focus on integrated approaches to mental health which achieve the triple aim of integration between mental and physical health, primary and secondary care and health and social care. Investment and re-design proposals will continue to be developed workstreams, the Mental Health Co-ordinating Committee and the four mental health alliances Psychological Therapies and Wellbeing, Primary Care Mental Health, CAMHS and Dementia. Through joint contracts and joint working the four alliances have to date delivered significant pieces of transformation and integrated care including a community dementia service, CAMHS transformation in schools, VSO IAPT with BME access and an alliance model of SMI physical heath checks.

There is a need for local authorities and the CCG to continue to develop integrated approaches to 117 and Personal Budgets, the Wellbeing Network, the accommodation and homelessness and substance misuse pathways.

The Mental Health Community Transformation programme which is funded up until the end of 2020-21 by NHSE will enable us to deliver

integrated mental health services within a neighbourhood framework. Key features of the model are:

- The establishment of blended mental health teams, containing East London Foundation Trust and VCSE staff co-located in each PCN/neighbourhood. The teams will be capable of conducting non-urgent assessments and providing care planning, navigation, treatment and support. They will also be integrated within the PCN/neighbourhood with physical health, social care and local community resources. We will review East London Foundation Trusts existing resources
- The provision of a neighbourhood based interventions for people with Personality Disorder and Trauma.
- This will involve additional resources and a review of East London Foundation Trust's existing psychological therapy and allied health professional resources to understand what could be better aligned to a neighbourhood model.
- Through more systematic joint working between GPs and psychiatrists we aim to improve the on-going monitoring of medication for those on SMI QOF and/or on anti-psychotics.
- Co-produced recovery care plans and an enhanced digital offer will support personalisation. This may include the use of online therapy packages which are currently being piloted by East London Foundation Trust working with Silver Cloud. We also explore online care plans and online access and booking systems. Mental health teams will have full access to EMIS and relevant information will be accessible on the EMIS system.
- The programme will shift care from secondary care community teams to the integrated mental health teams in PCNs/ neighbourhoods. Patient flows will be monitored and resources will be transferred from East London Foundation Trust community teams in line with this and the agreed programme plan.
- Both GP and psychiatrists will have responsibility for population based health supported by a neighbourhood level dashboard.

6. The City & Hackney Quality, Innovation, Productivity & Prevention (QIPP) intentions for 2020/21

Whilst commissioning intentions identify key changes that City & Hackney CCG seeks to make to the services next year, the increased demand for healthcare needs to be balanced through the delivery of transformation schemes.

For City & Hackney CCG, the delivery of its QIPP target remains a key priority for 2020/21. The programmes outlined below are a summary of the non-exhaustive areas at various stages of development, from exploring to implementation in progress proposed by the workstreams to ensure delivery of the CCG's net QIPP target of >£5m.

The challenging financial context and the need for QIPP savings in 2020/21 to achieve financial balance suggest that a more transformational approach is required. Hence, the need to work collaboratively to identify new ideas that will help sustain the financial health of the City & Hackney system whilst maintaining and improving quality.

The successful delivery of our QIPP targets will require co-production and proactive engagement from our Service Providers and other partners to support the identification, planning and delivery of CCG QIPP programmes that are currently being developed through the workstreams. These have been identified below:

Planned Care

i. Secondary Prevention Programme – Hypertension Patient Support programmes

ii. Secondary Prevention Programme – Respiratory

iii. Secondary Prevention Programme – Heart Failure Community Based IV Diuretic

iv. POLCE

v. Outpatient Transformation – including C2C *(full year effect)*

vi. Diagnostics

vii. FIT testing - *(full year effect)*

viii. GP Direct Access Pathology – Urea *(full year effect)*

ix. PSA Monitoring GP Shared Care – *(full year effect)*

x. Patient Transport

xi. Non PBR Tariff Service Benefit Review

xii. Primary Care Prescribing

xiii. Outpatient Transformation Virtual Fracture Clinic – *(full year effect)*

xiv. Ophthalmology- *(Full Year Effect)*

xv. GP Referral Variation – *(Full year effect)*

xvi. Tele-dermatology – *(Full Year Effect)*

xvii. CHC Domiciliary Care Brokerage AQP

Unplanned Care

i. Bart's Ambulatory care local pricing

ii. Falls Prevention

iii. End of Life Rapid Response – *(full year effect)*

iv. Non PBR Tariff Service Benefit Review

v. Redirection from A&E Bart's (royal London - Streaming) – *(Full Year Effect)*

vi. Reduction in Local tariff - A&E Streaming Bart's (royal London)

vii. Out of Area Mental Health Repatriation

CYP Mental Health

i. CAMHS Transformation Phase 3 – Demand / Capacity

Sign-off for the City and Hackney 2020/21 System Intentions

Board/ Committee	Date signed off
Unplanned Care Workstream Board	30/08/2019
CYPMF Care Workstream Strategic Oversight Group	19/09/2019
Planned Care Workstream Core Leadership Group	17/09/2019
Prevention Care Workstream Core Leadership Group	06/08/2019
City and Hackney Accountable Officers Group (AOG)- shared via email	25/09/2019
City and Hackney Governing Body	27/09/2019
Local GP Provider Contracts Commissioning Committee (LGPCCC)- (For Information only)	27/09/2019
City and Hackney Patient and Public Involvement (Summary Paper)	11/09/2019
East London Health & Care Partnership operational Delivery Group (ODG)	30/09/2019

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ANNEX A

DRAFT CITY AND HACKNEY 2020 - 21 SYSTEM INTENTIONS:

PARTNER SPECIFIC CHANGES

Version 3.1 – 23/09/19

NHS City and Hackney Clinical Commissioning Group

NHS East London NHS Foundation Trust

City of London

City & Hackney GP Confederation
A community interest company

NHS Homerton University Hospital NHS Foundation Trust

Hackney

Neighbourhoods Health and Care

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Respiratory Pathway review	Homerton Hospital GP Confederation	Increased capacity to provide community to support to people with respiratory conditions; increase Pulmonary Rehab, improve detection, improve quality of diagnosis and optimise medication usage	Reduced use of unplanned care; reduced prescriptions	Pulmonary Rehab has a very strong evidence base. Identifying and accurately diagnosing respiratory conditions at an early stage will improve health outcomes	Collaborative workshop with providers and commissioners by end 2019; Pathway redesign; Business Case
Develop community kidney disease management and dialysis offer	Homerton Hospital, Barts Health	Increased consultant capacity to deliver community facing component	Improved quality of life for C+H residents living with kidney disease; upskilling primary care to manage chronic kidney disease caseload	Capacity for dialysis is urgently required and a community service would offer care nearer home	Discussions with providers to develop model; Demand and capacity review
Pilot community iv diuretics and heart failure urgent community response service within ACERs	Homerton Hospital	Increased interim capacity to evaluate feasibility and value of enhanced community service	Reduced hospital admissions / earlier discharge	British Heart Foundation have provided a model for community iv diuretics with some evidence of outcomes and value for money. This project would expand on that and evaluate the local offer for this service	Design service and agree evaluation metrics Recruitment Implementation and evaluation
Stroke pathway redesign	Homerton Hospital Voluntary and Community Sector /Hackney CVS	Recommissioning revised voluntary sector offer – possibly via competitive tender. Provider alliance will be invited to assist with pathway design	• More streamlined offer for patients ideally incorporating, early support discharge, improved post stroke community support, peer support, exercise and improved vocational rehab offer. • Improved secondary prevention leading to reduced hospital admissions and reduced length of stay.	Initial engagement event has taken place with residents. There are some similar models in other areas for vocational rehab.	Mapping workshop Service specifications Tender process (if applicable).
Ophthalmology Virtual Clinics	Moorfields/ Primary Eyecare	Reduction in GP referred routine and follow-up ophthalmology appointments	• Shorter patient waits • More accessible service locations • Frees up capacity in ophthalmology outpatients • Meets expectations of Long Term Plan	Based on Moorfields Pilot- details shared as part of NHSE Elective Care Transformation Programme	• Agree Service Specification • Agree Contract • Rollout to service locations in City and Hackney

Neighbourhoods Health and Care Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Community Gynaecology Development: • Further service development to provide service for Networks • Work to develop Women's Health Services that include Gynaecology**.** • Embedding e-RS to improve access in 19/20	Homerton Hospital and Community Gynaecology Service.	Specialists to support activity to be provided via community and primary care	• Improve access for patients • Provide more education and training to GPs and primary care teams • Financial Saving • Women's Health service will provide more one stop services reducing patients having multiple appointments with separate services • Meets expectations of Long Term Plan	Long Term Plan	• Business Case Sep 2019 • Implementation Jan 2020
Community Acne Pathway • Develop Community service to see patients on a complete acne pathway including Isotretinoin where appropriate	Homerton Hospital and CHS Community Service	Dermatology specialists to provide acne care in partnership with community and primary care services	• Closer to home access • Shorter waits for patients • Financial Saving • Improved resource allocation in secondary care	Long Term Plan	• Agree case Nov 2019 • Agree changes to specification and contracting Dec 2019
ENT Community Service – A new provider is taking over from Oct 2019 which will deliver an improved service	Homerton Hospital/Barts Health	Integration with community pathways to ensure patients seen at right place/right time	• Closer to home for patients • Faster Referral to treatment • Meets expectations of Long Term Plan		• Agree with HUH access to ENT/Diagnostics - Oct 2019 • Review service Impact Apr 2020
MsK – Virtual self-referral and triage to services	CHS Locomotor/Primary Care	Provide virtual offer for self management and education including referral where appropriate to appropriate primary care. Community or secondary care services	• Meets expectations of Long Term Plan • Improve patient experience	Long Term Plan Reduce impact on resources Provides a digital offer	• Agree Project Implementation • Pilot service Apr 2020 • Full rollout Sep 2020
Community Navigation and Interpretation Service	Homerton Hospital	Develop the Bilingual Advocacy Service to offer community navigation and more equitable interpretation. Improving patient access and developing a more patient centred service.	• Improve access for patients • Improved virtual offer • Financial Saving	Long Term Plan	• Full rollout: April 2020

Neighbourhoods Health and Care Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Adult Community Nursing The transformation includes 3 elements: **1. Delivery of 8 neighbourhood nursing teams**. These teams will be a core part of the multi-disciplinary team in each neighbourhood in order to provide joined up, holistic and prevention focused care. **2. Delivery of a strengthened and more responsive access point into the service**. 45% of people referred to community nursing only need short term support. The new team structure includes a strengthened front end to the service which will deliver a fast assessment of all referrals, and short term care that supports people to return to living independently wherever possible. Those patients that require long term care will be passed onto the neighbourhood teams. **3. Delivery of effective specialist clinic based services**. DN responsibility includes wound care and continence clinics, currently these are distributed across the total workforce. In the new model, these teams will be distinct from the rest of the service, allowing us to maximise the clinical and operational model of this team, and taking pressure off the neighbourhood teams.	Homerton Hospital	Agreement will be sought regarding the contracting route for the new service, this will be the first test case within the scope of the new community services contract. Once the contract is agreed by all partners, the Homerton will initiate a workforce change process followed by implementation of the key elements of the new model in three distinct project phases. We anticipate that this will take 6-9 months to fully transition to the new service model.	The transformation will deliver a modern, fit for purpose community nursing service that is modern, delivers our ambitions for integrated teams within each neighbourhood and meets the needs of the City and Hackney population.	The Long term Plan	This will be in place within year one of the new contract going live.
Adult community therapies transformation The work on adult therapies has only just commenced, whilst the service model is not yet designed in detail, the following will be the key elements of the transformation: • There are a number of different community therapy teams with potential to deliver better care by working much more closely together (IIT, ACRT and SRT have been considered first within the initial scoping). • Community therapies will be a core part of each neighbourhood integrated multi-disciplinary team. • There should be a single point of access into these services that provide a rapid response and quickly sends people to the most appropriate team. In time, this may merge with the access point into community nursing.	Homerton Hospital	This service re-design will incorporate services that are not all within the scope of the new community services contract – IIT has a standalone contract whilst SRT is within the Homerton acute contract. This demonstrates how the new community services contract will still enable a joined up, system approach for transformation of services within and out with its scope and will not create new silos. We may also, in time. decide to pull IIT and/or SRT into the community services contract	Establishing efficient care pathways through therapy services that allow optimal use of resources and capacity and provide equity of access and waiting times.	The Long term Plan	

Neighbourhoods Health and Care Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Development of the anticipatory care service as part of the neighbourhood model, including the development of a core integrated team around each neighbourhood and an effective model of navigation. • Involving a formal MDT working for frail residents • Using community navigation as the key intervention for residents who are "failing to thrive".	London Borough of Hackney, Homerton Hospital, City of London, East London Foundation Trust, Primary Care, Voluntary Sector/Hackney VCS	Our Proactive Care Services, both Practice Based and Home Visiting, will form an essential part of the Anticipatory Care Model	• Ensure that the community navigation offer we have in City and Hackney can respond to the needs of the whole population. • Improving outcomes and value by more proactive and intense care for patients assessed as being at high risk of unwarranted health outcomes.	Long Term Plan	The development of integrated community teams within each Neighbourhood to deliver anticipatory care with a focus on developing ways of working which improve communication across professional boundaries and enhance collaboration and effectiveness. The community teams that will be prioritised for transformation around the neighbourhood model will be adult community nursing, dementia and SMI. Community therapies will be considered as a next step
Establish a model for how the neighbourhood structure provides a framework for effective involvement from the voluntary and wider community sector	London Borough of Hackney, Homerton Hospital, City of London, East London Foundation Trust, Primary Care, Voluntary Sector Partners	The Voluntary sector will develop a network model for organisations and community groups within Neighbourhoods building on learning from examples in Sheffield, Wigan and Manchester	• Developing strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible • Delivering models of care that support sustainability for the City and Hackney health and care system.	Long term Plan	

Neighbourhoods Health and Care (Mental Health)

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Mental Health Community Transformation Programme	East London Foundation Trust, GP Practices, GP Confederation, Voluntary Sector/Hackney VCS	I. The establishment of blended mental health teams, containing East London Foundation Trust and VCSE staff co-located in each PCN/neighbourhood. The teams will be capable of of conducting non-urgent assessments and providing care planning, navigation, treatment and support. They will also be integrated within the PCN/neighbourhood with physical health, social care and local community resources. We will review East London Foundation Trusts existing resources II. The provision of a neighbourhood based interventions for people with Personality Disorder and Trauma. III. This will involve additional resources and a review of East London Foundation Trust's existing psychological therapy and allied health professional resources to understand what could be better aligned to a neighbourhood model. IV. Through more systematic joint working between GPs and psychiatrists we aim to improve the on-going monitoring of medication for those on SMI QOF and/or on anti-psychotics. V. Co-produced recovery care plans and an enhanced digital offer will support personalisation. This may include the use of online therapy packages which are currently being piloted by East London Foundation Trust working with Silver Cloud. We also explore online care plans and online access and booking systems. Mental health teams will have full access to EMIS and relevant information will be accessible on the EMIS system. VI. The programme will shift care from secondary care community teams to the integrated mental health teams in PCNs/ neighbourhoods. Patient flows will be monitored and resources will be transferred from East London Foundation Trust community teams in line with this and the agreed programme plan. VII. Both GP and psychiatrists will have responsibility for population based health supported by a neighbourhood level dashboard provided by the Clinical Effectiveness Group.	Support for personalisation and greater self-management. Improved access.	Long Term Plan	

Prevention

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Making every contact count - embed MECC principles in all health and care service provision	TBC as part of programme development -this is a system wide intervention.	In 2020/21, funding will provided to co-design training for staff within provider organisations. Longer term, appropriate contractual levers will be used to embed as part of usual practice (TBC as part of programme development).	All frontline health and care staff will be empowered to have conversations with patients and the public about their health and wellbeing, to help embed prevention and support culture change across the system for lasting and sustainable population health benefits.	MECC is underpinned by a strong evidence base on brief advice and behaviour change interventions (including NICE).	Co-design and testing phase completed by Feb 2020 Early adoption and roll out commences March 2020 through March 2021. Evaluation report and sustainability plan finalised May 2021.
Re-commission the existing Social Prescribing service to integrate fully with new PCN provision (funded SP link workers)	Voluntary & Community Sector/ Hackney VCS, Primary care	Separate but integrated contracts to deliver a comprehensive Social Prescribing offer for all City and Hackney residents/patients.	Greater access to community networks and support to tackle the 'wider determinants' of health. More people are better supported to better manage their own health.	Long Term Plan	New CCG commissioned SP service to be in place by October 2020.
Refocus the LTC contract to have a stronger emphasis on incentivising prevention, including integration with NHS Health Check contract.	GP Confed, Primary care	Contractual changes to provide greater incentives for prevention activity	Earlier identification and intervention to reduce risk and consequences of LTCs. Patients better supported to manage their own health.	Long Term Plan	New contract in place from April 2020
Weight management services • **Tier 3 weight management services (see Planned Care system intention)** • **Review current provision of 'Lifestyle' (tier 2) weight management service including options for an integrated T2/T3 pathway**	Homerton Hospital Voluntary & Community Sector(current tier 2 provider)	Tier 3 - see Planned Care system intention Collaboration in development of tier 2 and integrated pathway plans	Tier 3 - see Planned Care system intention Improve access to weight management support. Reduce obesity prevalence and related health harms.	Tier 3 - see Planned Care system intention NICE, NHSE and BOMSS commissioning guidance	Tier 3 - see Planned Care system intention Review of tier 2 provision and new service/pathway design to take place during 2020/21. New tier 2 service in place by July 2021..
Embed treatment of tobacco dependency within NHS pathways	Homerton Hospital, East London Foundation Trust	Tobacco screening and brief advice targets included as contract KPIs. Collaboration with NEL partners to develop a business case to implement the 'Ottawa' model of bedside support to quit.	Improve access to evidence-based support to quit. Reduce smoking prevalence Reduce smoking-related admissions. Reduce smoking related health inequalities and premature mortality.	NICE Long Term Plan	New contract KPIs in place from 1 April 2020

Prevention Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Complete procurement of new City and Hackney adult substance misuse service	TBC, likely Voluntary & Community Sector (VCS)	New contract to be awarded through competitive process	Various service improvements to better meet the diverse needs of people with alcohol as well as substance misuse, and improve access to mental health support for those who misuse substances	NICE	New service go live date Oct 2020
With the Planned Care Workstream, develop a collaborative approach to commissioning women's sexual and reproductive health (see Planned Care system intention)					
Re-commissioning of 'Wellbeing Network' as a targeted preventative service for better mental health	TBC (existing Voluntary & Community Sector Provider network)	New contract to be awarded via competitive process	Better access to support for positive mental wellbeing and reducing risk of future mental ill-health	City and Hackney Mental Health Strategy Evaluation of the Wellbeing Network	TBC
Supported Employment Network - implementation of programme plan	Voluntary & Community Sector (VCS), London Borough of Hackney	Access to training and accreditation. Better communication and greater collaboration between providers.	Easier and coordinated access to supported employment provision for people with mental illness, learning disability and other support needs. Greater choice of career opportunities and sustainable employment for disabled people.	Long Term Plan NHSE IPS programme	
Embed alcohol screening and early intervention in NHS pathways	Homerton Hospital, East London Foundation Trust	Alcohol screening and brief advice targets included as contract KPIs	Improve access to alcohol brief advice and treatment services. Reduce alcohol-related ED attendance and hospital admissions. Reduce personal, family and societal harms from alcohol.	NICE Long Term Plan	New contract KPIs in place from 1 April 2020

Outpatient Transformation

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
OUTPATIENT TRANSFORMATION					
Continuation of the work started in 2018 and now aligned to the long term plan	Specifically Homerton Hospital but also Primary Care and community providers such as GP Confed	Change the way outpatient specialist care is delivered. Increased use of non-face to face methods of care	Specifics shown below against individual projects Overall aims • Prevent unwarranted first attendance/referral and reduce unnecessary routine face to face follow ups • Reduce overall face to face appointments by up to a third in 5 years (LTP target) • Optimise what should be done in secondary care and by whom • Financial savings to the system	Long Term Plan to deliver 30% less face to face contacts in outpatients in 5 years	
Contracting/Payment Model	Homerton Hospital				Agree model to shadow outpatients
Develop and implement a model of payment for services that incentivises change to virtual and other alternative models of care	Homerton Hospital		Same as above		Implement shadowing

Outpatient Transformation Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Virtual Fracture Clinic (Full Year Effect) This service change started in July 2019 and the full impact will not be achieved until end of July 2020	Homerton Hospital	First appointments will become Virtual MDT team of consultant and physio.	• Reduce patient waiting times • All referrals reviewed by Specialist • Financial Saving • Meets expectations of Long Term Plan	Recommended pathway	• Already in place
Rheumatology Tele FU Clinics: • Pilot to establish Appointment based Specialist Telephone Clinics	Homerton Hospital	Homerton Hospital to propose pilot as part of outpatient transformation	• Improved Patient Experience • Reduces need for resources • Meets expectations of Long Term Plan		• Pilot approval Sep 2019 by OT SG • Review pilot Jan 2020 for full implementation
Improve referral and service offer for colposcopy and Hysteroscopy (Gynaecology Procedures)	Homerton	Provide one stop access for procedures Reduce inappropriate GO referrals so procedures can be provided at first appointment as the norm.	• Improve access • Reduce inefficiency • Improve patient pathway • Meets expectations of Long Term Plan	National Guidance for Colposcopy	• Agree and implement referral guidance Sep 2019 • GP Masterclass – Colposcopy – Nov 2019 • One stop Clinics for Hysteroscopy

Outpatient Transformation Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Outpatient Transformation - Linked to Neighbourhood Community Programme - New Models of Care					
Sub-Cut Methotrexate development **58 patients are attending for regular routine injections – an alternative pathway will be introduced.**	Homerton Hospital	Rheumatology to provide services in partnership with community and primary care	• Closer to home • Reduce transport environmental footprint • Right place/right time • Financial saving	Meets aims of Long Term Plan	Develop change in model - Sep 2019
PSA monitoring for Stable Prostate Cancer Patients in Primary Care					
GP Direct Access Pathology: • In partnership with Homerton Pathology we will be engaging GPs with clinical guidance to reduce pathology testing that is not clinically indicated.	Homerton Hospital	Reduction in GP direct access pathology testing that is not clinically indicated	• Frees up capacity in Pathology Laboratory • Frees up primary care time processing results • Reduces risk of unnecessary clinical interventions based on results • Improved patient experience as they do not need to go through testing that is not clinically indicated • Delivers a financial saving	Based on WEL Diagnostics Programme- focus on the following: · Vit B12 · Fertility · Polycystic Ovary Syndrome · GP Variation · Tired all the Time · GP Variation • Removal of MG from Bone Profile • Vitamin D change to a single test- Bone Profile and MG removed • AST removed from Acute Hepatitis Profile HPA	• Agreement on the Pathology Tests and Groups that will be focused on in 20/21 • Implementing changes to tQuest, including pop-ups, creation of groups, removal from home screen. • GP Education Session to support changes.

Outpatient Transformation Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Radiology **In partnership with Homerton Pathology we will be engaging GPs with clinical guidance to reduce radiology testing that is not clinically indicated.**	Homerton Hospital	Reduction in GP Direct Access Radiology testing that is not clinically indicated	• Frees up capacity in Radiology • Frees up primary care time processing results • Reduces risk of unnecessary clinical interventions based on results • Improved patient experience as they do not need to go through testing that is not clinically indicated • Delivers a financial saving	Based on WEL Diagnostics Programme- focus on the following: · MRI for MSK · Brain MRI Scans · Thyroid Ultrasound · Ultrasound for lumps/ bumps	• Agreement on the scans that will be focused on in 20/21 • Implementing changes to tQuest, such as pop-ups • GP Education Session to support changes.
Continuing from 2019/20					
Tele-dermatology (Full Year Impact)	Homerton Hospital and Homerton CHS Dermatology Service	Reduction of a further *** Dermatology First appointments. Also estimated reduction of CHS activity by 800	QIPP Net Savings of £	Continuation of service launched in 19-20 and service reporting.	Comprehensive review of service performance following 12 months of all C&H GP Practices being operational
Enabling GPs to send photos of dermatology conditions to Homerton Dermatology for specialist review, including advice and guidance and onward referral where required			• Freeing of CHS Capacity to provide Community Acne Pathway • Patients diagnosed and treated closer to home • Specialists freed up to provide more complex care capacity		
GP Variation – Quality Improvement	Homerton Hospital, Barts Health Health, University College London Hospital, Moorfields Eye Hospital	Reduction in GP referred routine outpatient appointments	Improved utilisation of community services	Continuation of service launched in 19-20 and service reporting	Staged roll out to practices
GP engagement on routine outpatient referral rates and utilisation of community services/local pathways			• Patients seen a service context that reflects the complexity of their condition. • Frees up capacity in the relevant specialties • Delivers a financial saving		Mid-year comprehensive review of service performance

Outpatient Transformation Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
PSA monitoring for Stable Prostate Cancer Patients in Primary Care	Homerton Hospital, GP Confederation	Reduction in Urology follow-ups	Frees up capacity in Homerton Urology	Service model running in Croydon and NCL	Ongoing discharge of patients to primary care as they attend for follow-up appointments
			Patient can receive follow-up and ongoing monitoring at their local GP Practice.	Continuation of service launched scheduled to launch in 19-20 and service reporting	Business as usual transition once existing caseload are all discharged
			Reduced risk of patients 'lost to follow up' through the use of CEG searches		
Tier 3 - Weight Management Service (this is a prevention and Planned Care workstream initiative)	Homerton Hospital	Current Bariatric Outpatient and Dietetic Activity will reduce to provide block CHS service for City and Hackney Patients	Ensure patients have access to a specific pre surgical service Provide better outcomes for both surgical and non-surgical patient pathways		Agree specification and contract by Dec 2019 Commence referrals to service by March 2020.
Aligning Commissioning Policies for PoLCE for NEL: • Implementation of the new policy and monitoring arrangements	Homerton Hospital /Barts Health and Out of area acute providers	Additional Procedures will have criteria requirements that will reduce activity – mostly in day-case procedures	• Focus resources on improving patient outcomes • Equity for all NEL patients • Financial Saving	National and London policies are being implemented. The majority will be in accordance with NICE guidelines	• Agreement of clinical policy Sep 2019 • Agreement of implementation and monitoring with providers/referrers Dec 2019
Ophthalmology Virtual Clinics	Moorfields Eye Hospital/ Primary Eye-care	Reduction in GP referred routine and follow-up ophthalmology appointments	• Shorter patient waits • More accessible service locations • Frees up capacity in ophthalmology outpatients • Meets expectations of Long Term Plan	Based on Moorfields Pilot-details shared as part of NHSE Elective Care Transformation Programme	• Agree Service Specification • Agree Contract • Rollout to service locations in City and Hackney

Outpatient Transformation Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Outpatient Transformation - Linked to Neighbourhood Community Programme - New Models of Care					
Sub-Cut Methotrexate development: • 58 patients are attending for regular routine injections – an alternative pathway will be introduced.	Homerton Hospital	Rheumatology to provide services in partnership with community and primary care	• Closer to home • Reduce transport environmental footprint • Right place/right time • Financial saving	Meets aims of Long Term Plan	Develop change in model - Sep 2019
PSA monitoring for Stable Prostate Cancer Patients in Primary Care					
GP Direct Access Pathology: • In partnership with Homerton Pathology we will be engaging GPs with clinical guidance to reduce pathology testing that is not clinically indicated.	Homerton	Reduction in GP direct access pathology testing that is not clinically indicated	• Frees up capacity in Pathology Laboratory • Frees up primary care time processing results • Reduces risk of unnecessary clinical interventions based on results • Improved patient experience as they do not need to go through testing that is not clinically indicated • Delivers a financial saving	Based on WEL Diagnostics Programme- focus on the following: · Vit B12 · Fertility · Polycystic Ovary Syndrome · GP Variation · Tired all the Time · GP Variation • Removal of MG from Bone Profile • Vitamin D change to a single test- Bone Profile and MG removed • AST removed from Acute Hepatitis Profile HPA	• Agreement on the Pathology Tests and Groups that will be focused on in 20/21 • Implementing changes to tQuest, including pop-ups, creation of groups, removal from home screen. • GP Education Session to support changes.

Integrated Urgent Care

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Implementation of streaming and redirection model at the front door of A&E Embed and test a model of Streaming and Redirection at the front door of A&Es ensuring that our patients are in the right place and at the right time according to their clinical need. This will include redirecting patients to their primary care provider.	Homerton Hospital Barts Hospital/Tower Hamlets GP Care Group C&H GP Confederation	Creating services that are more joined up and person centred: 'services that work for me'	• Provision of consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information • We will work together to prevent avoidable emergency attendances and admissions to hospital	Alignment to integrated commissioning priorities	
Maximise use of appropriate care pathways (Paradoc, IIT, MH crisis line) working with LAS and primary care	LAS Homerton Barts Health UCLH GP Confederation			Alignment to integrated commissioning priorities	
Implement an effective out of hours primary care services - 111, extended access hubs, GP OOH • 111 IUC - embed and develop the NEL IUC (111 & CAS) service as the single point of telephone access to our urgent care system. • OOH primary care - support/work with local providers of urgent primary care services (including new GP OOH service) to better integrate with NEL IUC and each other to provide less fragmented urgent care services to our local residents. • Work with INEL colleagues to agree principles for delivery of urgent primary care and identify opportunities for collaborative working.	LAS Homerton C&H GP confederation Tower Hamlets GP Care Group	• The development of an integrated model of urgent care services for City and Hackney. • Ensuring that services provide clear and easy pathways for patients to navigate, avoiding fragmentation, and managing demand away from A&E where possible	• Provision of consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information • Developing urgent care services that provide holistic care and support people until they are settled • Preventing avoidable emergency attendances and admissions to hospital • Providing timely access to urgent care services when needed, including at discharge • Delivering models of care that support sustainability for the City and Hackney health and care system.	Long term Plan	

Integrated Urgent Care Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Duty doctor review	GP Confederation	A review of the Duty Doctor Service is taking place in 2019/20 and learning from the review will guide future changes to the service in order to best utilise the resource across the system.	• Provision of consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information • Development of urgent care services that provide holistic care and support people until they are settled • Preventing avoidable emergency attendances and admissions to hospital • Provision of timely access to urgent care services when needed, including at discharge • Delivering models of care that support sustainability for the City and Hackney health and care system.	Alignment to integrated commissioning priorities	Review of the Duty Doctor Service to take place in 2019/20
Implementation of new high intensity users service	Homerton Hospital, East London Foundation Trust, Tavistock Family Action, Volunteer Centre Hackney,	Following an interim review of the new High Intensity User Service which will take place in 2019/20, we anticipate an extension of the pilot which incorporates learning from year 1 and a better understanding of our high intensity user population in C&H. What form the service will take will depend on the interim review due to be completed in 2019/20. The service will continue to support patients who most frequently attend A&E or call 999 or 111. We also plan to explore how we can work across north east London to better support and manage patients that attend multiple A&Es.	• Preventing avoidable emergency attendances and admissions to hospital • Delivering models of care that support sustainability for the City and Hackney health and care system. • Improving the mental health and wellbeing of the local population	NHS Rightcare	Interim review of the new High Intensity User Service due to be completed in 2019/20.

Integrated Urgent Care Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones

Improvements and enhancements to falls pathway
Continue to deliver programme of work to improve our falls response and falls prevention services in C&H;
• Falls response : Ensuring that we have a robust community response to mitigate unnecessary A&E / admissions.
• Falls interventions / prevention services :
  • Ensuring that those at risk of falls are identified, assessed & appropriately referred for prevention services
  • Ensuring availability and appropriate use of effective evidenced based interventions
  • Review of current falls rehabilitation and prevention services to ensure that there are no gaps or duplication in provision and that there is evidence of positive impact.
 	
Work with Prevention Workstream to identify further opportunity to reduce the risk of falls though a wider whole system approach, including primary as well as secondary prevention.
	LAS (999 /111)
	Telecare - Millbrook
	Residential / Nursing Homes
	Domiciliary Care
	Homerton Hospital
	C&H GP confederation / Primary care
	MRS Independent Living
		• Embedding referral pathways from LAS and 111 into ParaDoc (ACP intention)
		• Evaluation of ParaDoc Falls service pilot to assess whether it has improved urgent community management of falls and inform long term commissioning decision
		• Explore the best way for GPs to be notified about patients with potential risk of fall and fragility fracture (through care received in other settings) to ensure that they receive appropriate assessment and intervention.
		• Evaluation of OTAGO home exercise pilot to assess whether it has had a positive impact of falls prevention in order to inform long term commissioning decision
		• Work with LBH to recommission the Hackney community falls prevention service that includes strength and balance classes and home hazard assessment
			• The development of urgent care services that provide holistic care and support people until they are settled
			• Preventing avoidable emergency attendances and admissions to hospital
			• Delivery of models of care that support sustainability for the City and Hackney health and care system.
			• Improving the quality of life; Increasing the length of a healthy independent life
				Alignment to integrated commissioning priorities	

Review of ambulatory care services In accordance with the long term plan we plan to provide Same Day Emergency Care (12 hours day / 7 days week), delivering 30% of non-elective admissions via SDEC.	Homerton Hospital, Barts Health	• A review of the Homerton Ambulatory Care Service is taking place in 2019/20 and learning from the review will guide how Homerton Ambulatory Care Unit can work best with partners across the system to make best use of the resources we have available in 20/21. • Based on the work which Monmouth Partners have completed on Ambulatory Care at Barts Health it is our intention to reach agreement with Barts Health on a local price for Ambulatory Care for City and Hackney Patients.	• Preventing avoidable emergency attendances and admissions to hospital • Providing timely access to urgent care services when needed, including at discharge • Delivery of models of care that support sustainability for the City and Hackney health and care system. • Creating services that are more joined up and person centred: 'services that work for me'	Alignment to integrated commissioning priorities, Long Term Plan	• A review of the Homerton Ambulatory Care Service in 2019/20 • Implementation – 2020/21
Engage with the public to increase awareness of urgent care services	Healthwatch Hackney Community Voices Urgent care partners - Homerton Hospital GP confederation TH GPCG LAS	We will work with Healthwatch Hackney and Community Voices to maximise our engagement with patients and residents through application /delivery of a range of approaches: • Targeted engagement events in different settings throughout the borough • Visit community groups and forums that represent specific cohorts (that are often not represented in existing groups) • Establish resident involvement groups • Visit existing service user groups	• Preventing avoidable emergency attendances and admissions to hospital	Alignment to integrated commissioning priorities	

Integrated Urgent Care Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Progress blended payment - the new tariff for emergency hospital care	Homerton Hospitals, Barts Health	19/20 was the first year of the blended payment for emergency care activity in acute hospitals. We will review how well this has functioned in 19/20 and consider how we can strengthen its usage to provide effective incentives for system management of unplanned care demand in 20/20. This will include where we set the baseline and the thresholds for over or under performance. We will work closely with Barts and the Homerton on this.	Prevention of t avoidable emergency attendances and admissions to hospital	Alignment to integrated commissioning priorities	
Multi-disciplinary care notes review action plan The MDCNR undertaken in 2017 led to the development of a broad action plan intended to reduce inappropriate admissions to hospital. Many of the actions have been completed but a few remain outstanding including: • Ensuring that we do realise benefits from a range of new services / pathways that have been put in place or will be put in place following the action plan. These include substance misuse, dementia, catheters, weekend discharge teams and a range of ambulatory care pathways .	Homerton Hospitals, GP Confederation	Consideration for further culture change across the urgent care pathway to support and empower all partners to make appropriate and informed decisions on whether to admit patients or not		Alignment to integrated commissioning priorities	
Working with public health to support procurement and implementation of a new substance misuse service	WDP, Homerton Hospitals			Alignment to integrated commissioning priorities	The current drug and alcohol services in Hackney and the City are due to end in October 2020. I. The new contract for the entirety of the service will be awarded in February 2020 II. Mobilisation to take place Q1-Q2 20/21. III. Go live for the new service in October 2020
Ongoing roll out and realise benefits from CMC care plans - including introduction of My CMC		With the development of an Anticipatory Care Model CMC care planning will become core mainstreamed behaviour for Health Care Professionals working with the cohorts of patients identified in C&H as being suitably offered a CMC care plan.	Ensuring that where appropriate patients are offered the opportunity to utilise My CMC and initiate their own care plan which is then completed in collaboration with their GP Practice.	Alignment to integrated commissioning priorities and LTP	In 2020/21 we will continue to focus our efforts on ensuring better access to those care plans by the wider urgent care system and that the care plans are of sufficient quality to be fit for purpose

Improving Patient Discharges

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Continuing from 2019/20					
Delivery of DToC case notes audit action plan	Homerton Hospital, London Borough of Hackney, Age UK	Following implementation of a delayed transfers of care action plan in 2019-20, continue to ensure patients and families receive clear information about discharge upon admission to hospital, and that they are fully involved in all discharge planning.	• Developing urgent care services that provide holistic care and support people until they are settled • Providing timely access to urgent care services when needed, including at discharge	Alignment to integrated commissioning priorities	
Review and sustainable implementation of discharge to assess (or other) model	Homerton Hospital, London Borough of Hackney	Following a review of the discharge to assess pilot service in 2019-20, we anticipate implementation of a sustainable D2A model with a strengthened single point of access, enabling a home first approach.	• Developing urgent care services that provide holistic care and support people until they are settled • Providing timely access to urgent care services when needed, including at discharge • Delivering models of care that support sustainability for the City and Hackney health and care system.	Alignment to integrated commissioning priorities	
Improved primary care and wider system support to our local care home residents	PCNs, Homerton Hospital , Care Homes, Dementia Alliance, St Joseph's Hospice	Implementation of the Enhanced Health in Care Homes framework, enabling care home residents to be well supported within the community	• Developing strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible • Preventing avoidable emergency attendances and admissions to hospital • Delivering models of care that support sustainability for the City and Hackney health and care system.	Alignment to integrated commissioning priorities	

Improving Patient Discharges Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Continuing from 2019/20					
Review of Intermediate care services and interim care bed provision	Homerton Hospital, London Borough of Hackney	The Unplanned Care Workstream IIT Steering Group will review service demand and capacity and plan for recommissioning of an intermediate care service over 2019-20 ensuring clear links with the Neighbourhood Health and Care change programme and implementation of a revised discharge to assess service and delivery of the LTP asks around urgent response within 2 hours and access to reablement within 2 days	• Developing urgent care services that provide holistic care and support people until they are settled • Providing timely access to urgent care services when needed, including at discharge • Delivering models of care that support sustainability for the City and Hackney health and care system.	Alignment to integrated commissioning priorities and LTP	The current Integrated Independence Team (IIT) contract is due to end October 2020 Any changes to our Intermediate Care Service to go live in November 2020.
Better pathways for homeless people coming out of hospital.	Homerton Hospital, London Borough of Hackney, St Mungo's Hostel, Green House Practice.	Following work across 2019-20 to review the Pathways model supporting homeless patients, embed pathways and protocols for homeless patients coming out of hospital to ensure patients are not discharged to the street.	• Reducing inequality in health and wellbeing (including closing the health and wellbeing gap for people with long term conditions and co-morbidities)	Alignment to integrated commissioning priorities	
Improved support to local care homes, and improved working between care homes and hospitals - including introduction of trusted assessor and red bag scheme	Homerton Hospital , London Borough of Hackney, Care Homes	Following a pilot Trusted Assessor and Red Bag scheme over 2019-20, we will implement a hospital transfer pathway to ensure care home residents transition smoothly between care settings.	• Providing timely access to urgent care services when needed, including at discharge • Delivering models of care that support sustainability for the City and Hackney health and care system	Alignment to integrated commissioning priorities	

End of Life Care

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Implementation of new Urgent end of life care service: • We will commission an Urgent End of Life Service for one year (24/7 crisis response for people to be cared for at home) to see if it has a positive impact on provision of care for patients in their last year of life	St Jo's, Marie Curie, Homerton Hospital		• Increased achievement of preferred place of care and preferred place of death • Improved patient/carer assessment of quality of care at the end of life • Reduced unnecessary admissions at end of life • Reduced deaths in hospital	Alignment to integrated commissioning priorities	
Better support at end-of-life for homeless people, working with local hostels	Homerton Hospital , LBH, St Mungo's Hostel, St Joseph's Hospice, Green House Practice.	Continued work with LBH commissioners, hostel providers, primary care and community services to ensure that hostel residents have access to services and are fully supported at end of life.	• Developing urgent care services that provide holistic care and support people until they are settled • Preventing avoidable emergency attendances and admissions to hospital. • Reducing inequality in health and wellbeing (including closing the health and wellbeing gap for people with long term conditions and co-morbidities)	Alignment to integrated commissioning priorities	

Long Term Conditions

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Progress towards the faster cancer diagnosis standards as part of the Long Term Plan - 28 days	Homerton and other acute providers/Primary Care	• Increasing the proportion of cancers diagnosed early, from a half to three quarters in the next 10 years	• Faster diagnosis • Improved patient outcomes and long term survival rates	Long Term Plan	
Network level community diabetes service incorporating MDT education	Homerton Hospitals, Primary Care Network	• Closer ties to existing service on a network level. Introduce network education sessions for primary care staff	• Upskilling primary care to manage increasing diabetes caseload	Evidence from other areas that have introduced a similar model shows, improved primary care skills and more developed relationships between primary and secondary care	Work with PCNs and providers on design Implement and Evaluate

Learning Disabilities

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Co-produce a Learning Disabilities Strategy Action Plan & LD Charter for City & Hackney	Any who provides services to learning disabled & Autistic people in City & Hackney.	Services will be accessible to learning disabled people	Learning disabled and Autistic residents are able to access services in City and Hackney.	Coproduction Work	An action plan for the strategy is coproduced.
Coproduce an Autism Strategy & Action Plan for City & Hackney		Services will be accessible for autistic residents	Learning disabled people are valued for the contribution they make to society.	Learning Disabilities Partnership Forum work.	Launch of the LD charter.
			Learning disabled people are able to access life opportunities.	Work of the Autism Alliance Board.	The LD Charter is used by organisations to ensure good practice with learning disabled people.
					The Autism Strategy and Action plan is approved and implemented.
Where I Live & Independence					
Ensure Systems are in place for contractual and personalised provision for support and accommodation.	ILDS (Integrated Learning Disabilities Service), Third Sector,	They will be able to use a system that supports formalised, fair processes (rather than the current ad hoc provision).	Services are personalised and work in an integrated way to make things better for people with learning disabilities.	The Care Act	Individual placement agreements in place for residential, nursing and CHC provision in place.
	SLS and other accommodation and care providers	They will need to demonstrate that they have met requirements to provide quality support/ services.	Formalised, regulated processes put in place.	Personalisation Agenda	Implementation of a spot purchasing system, e.g. Dynamic Purchasing System, DPS, or similar.
			Better regulation of spot purchase arrangements.	EU procurement regulations.	Individual Service Funds Pilot evaluated.
			Learning disabled people and their families have more options around choice and control in the services they receive.	CHC Guidance	Implementation of Personal Budgets and associated processes.
			Learning disabled people have access to good quality housing and have a place they call home.		

Learning Disabilities Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Shared Lives	Hackney Shared Lives Service	There is clear service direction for Shared Lives.	Service users are able to access a good Shared Lives Service if they choose to do so.	CQC	A new service specification and local area agreement is in place for Shared Lives.
	Community Mental Health & ILDS		Shared Lives continues to deliver good value for money service.		Plans to develop Shared Lives are in place.
My Health					
Address the key Health Inequalities for People with Learning Disabilities & Autism locally.	GPs & Primary Care Services.	Links strengthened with primary care & the neighbourhood model.	Learning disabled & autistic people have good access to the health care they need.	NHS Long Term Plan	Training delivered to GPs
	Mainstream Health.	Mainstream health staff will be skilled, confident and better able to work with learning disabled service users who have an LD/are autistic. Local strategies in place to support health needs and reasonable adjustments.	Unnecessary admissions to hospitals and Assessment & Treatment Units (ATUs) are avoided.	Transforming Care Programme	Targets for LD Register, annual health checks and health action plans achieved.
	ILDS		Plans are in place to make sure that when someone does need an admission that they can be successfully discharged back into the community.	Leder Programme	Learning from Leder reviews is put in place.
	Advocacy		Learning disabled people do not die prematurely (compared with non-learning disabled population).	Homerton Strategy for Learning Disabilities	Review of accessibility of inpatient provision (mental health).
				JSNA Learning Disabilities Chapter	Improved community provision of specialist support services for those with challenging behaviour
				CIPOLD [Confidential Inquiry into the Premature Deaths of People with LD.	Achievement of actions concerning healthcare as laid out in the Autism Strategy Action Plan.
				Learning Disabilities Improvements Standards for NHS Trusts.	Reasonable adjustments are made in key health services for learning disabled and autistic people.

Learning Disabilities Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
My Community					
Independence					
Review and development of day opportunities for learning disabled adults.	Day service providers	Multi-agency approach to improving employment opportunities for learning disabled	Learning disabled people are an active part of their community	3 Conversations Model	Review completed of current day service provision.
	Hackney Works		Learning disabled people are enabled to achieve independence where possible	Care Act	
	ILDS		Learning disabled people are able to get into and retain employment.	Community Assets work - various.	
			Learning disabled people are valued for the contribution they make to society.		
			Learning disabled people are part of social networks.		
Support City and Hackney to become autism friendly	Local businesses	Businesses will be encouraged to apply for an autism friendly accreditation	Autistic people are able to access businesses in City and Hackney	City and Hackney Autism Strategy	Businesses are signed up to NAS autism friendly award
		Businesses will be able to access autism training		Think Autism	
Autism Services post diagnosis	TBC - Possible mental health and/or ILDS community team	They will be responsible for delivering an enablement support service for autistic adults.	Autistic people will have access to preventative services, so they do not go into crisis and know how best to access the support /advice they need.	Autism Strategy	An autism Hub is set up.
			Autistic people will have support post diagnosis to help understand what being autistic means for them	Commissioning autism services (draft DHSC guidance)	An Enablement service is considered and scoped,
			Autistic people will know where to go for support with managing independence and daily living skills	City and Hackney Autism Strategy	There is an enablement service for autistic people.
					Achievement of actions in relation to managing independence in City and Hackney Autism Strategy

Mental Health

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Section 117					
Establish a joint process for s117 patients across the system including the review of all existing packages of care.	East London Foundation Trust	Creation of an integrated process and agreement for joint funding packages of care between health and social care.	a) Creation of an integrated process and agreement for s117 packages of care.	Mental Health Act 1983 s117	Q2 20/21 – Processes established.
NHS and Local Authority Commissioners to determine the scope of PHBs funding in relation to the wider 117 package.	Adult Social Care Service (London Borough of Hackney & the City of London)	Scope of funding in relation to PHBs agreed between NHS and Local Authority Commissioners	b) Clear PHB offer to patients on s117.	Health and Social Care Act 2012	
	Voluntary, community and soci al enterprise sector			Care Act 2014	
				City and Hackney Joint Mental Health Strategy	
Improving Access To Psychological Therapies (IAPT)					
Expansion of IAPT services in line with the NHSE access requirements through the development of IAPT specialist offer including LTC, autism, perinatal.	IAPT providers	Greater alignment between long term conditions psychology who currently sit outside the IAPT service and mental health wellbeing.	a) Improved links between physical health and the wider determinates of mental health wellbeing. b) IAPT will be a central part of the neighbourhood mental health offer for people with common mental health problems.	a) FYFV evidence base b) See national requirement	NHSE increased access target of 25% by Q4 2020-21.

Mental Health Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
			c) Greater integrated alignment in Mental Health	c) Service data reports on inequities in access	
			d) Addressing the current unmet MH needs for people with LTCs in line with national strategy.	d) Silver Cloud evidence of productivity increases through use of online therapies.	
			e) Improved contractual performance in relation to the delivery of recovery and clinical improvement e.g. increased payment for delivering better outcomes for patients.		
			f) Improving the breadth of offer to patients who may have difficulties accessing services as they currently stand. Specifically younger males who currently don't access the service when compared to other groups.		
			g) Increase cost / effectiveness owing to improvements in productivity.		
Accommodation pathway					
a) Redesign of high needs residential services with East London Foundation Trust	East London Foundation Trust	A joined up health and local authority approach to mental health accommodation	a) A joined up health and local authority approach to mental health accommodation	City and Hackney Joint Strategic Needs Assessment Mental Health and Substance Misuse	Q2 2020/21: Redesign of residential services completed
b) Strengthen CHC offer for adult mental health	Mental Health Accommodation Providers		b) Increased use of floating support	City and Hackney Joint Mental Health Strategy	Q1 2021/22 – new pathway with contracts in place
c) Review the role of the East London Foundation Trust rehabilitation team and if the model could be expanded to support people with Learning Disability returning to local services			c) Greater throughput in the system with reduced numbers and reduced lengths of stay in high needs areas		
			d) Greater service user autonomy		
			e) Improved value for money.		

Mental Health Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Ensure autistic people are able to access mental health support	Mental Health Services	Mental Health staff will be skilled and confident to support autistic people with co-occurring mental health problems	Autistic people have good access to appropriate mental health support	JSNA Autism chapter	Achievement of actions in relation to mental health in City and Hackney Autism Strategy
			Autistic people feel better informed about co-occurring mental health conditions and have a say in related treatment	Think Autism	
				City and Hackney Autism Strategy	
Review of inpatient bed usage	East London Foundation Trust	Review of bed usage to determine optimal bed base for future years and to assist estates options appraisals and to find ways to reduce unnecessary bed usage			Development of an agreed planned bed base for future years.
			Clarity for planning purposes. Reduction in unnecessary bed use	London Wide Bed benchmarking and INEL bed benchmarking which indicate City and Hackney has relatively high bed usage	

Mental Health - Dementia

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Implementation of new City and Hackney dementia service	East London Foundation Trust, Alzheimer's Society, Homerton Hospital	The new City and Hackney dementia service will go live in Q3 2019. This will provide significantly enhanced support to people to access diagnosis and ongoing care and navigation. In 2020 we will work to embed the service to work well with adult social care and the urgent care system partners	• Improving the mental health and wellbeing of the local population • We will provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information • Preventing avoidable emergency attendances and admissions to hospital • Delivering models of care that support sustainability for the City and Hackney health and care system.	Alignment to integrated commissioning priorities	• New City and Hackney dementia service go live: Q3 2019. • Embedding the service to work well with adult social care and the urgent care system partners: 2020 -21

Continuing Healthcare

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Continue to implement recommendations of the INEL Continuing Healthcare services review to improve delivery of CHC services.	Homerton Hospital, NEL CSU	Working arrangements and role descriptions may change.	• Better integration of a fragmented pathway.	INEL Review	TBC
Continue to increase utilisation of personal health budgets across Continuing Healthcare, Mental Health Recovery and for Wheelchair users. Ensure there are clear links with social prescribing, and expand to new areas.	Homerton Hospital, NEL CSU, East London Foundation Trust, Advocacy Project,	Staff to develop personalised, holistic care and support plans to meet client needs.	• Personal health budgets (PHBs) are a lever for giving people more control of their health.	LTP	
	St Mungo's Hostel		• Increased quality of life for patients resulting from personalised care and support plans.		
Embed learning and potentially expand services to care homes following pilot at Mary Seacole Nursing Home to further develop a holistic assessment and care planning approach to improve quality of life, and minimise secondary complications through preventative, proactive multidisciplinary care and support planning for residents.	Homerton Hospital, Care Homes, GP Practices	Commitment to MDT working takes additional time for staff	• To improve the quality of life for patients in Care Homes through proactive AHP assessment and intervention, training and education. • Staff feel supported to develop holistic care plans and meet personalised client needs • To minimise secondary complications for complex patients through preventative care planning and training.	Enhanced Health in Care Homes Framework	TBC
Integrate health and local authority systems and processes to enable provision of joint funding packages and fit for purpose case management. The system will include a tool to support use of personal health budgets within CHC.	London Borough of Hackney, City of London, Homerton Hospitals, NEL CSU,	Processes and systems for LA funded users and CHC patients may change.	• Better join up between systems to support patient pathways • Supporting and empowering patients and carers to self-care and to navigate our complex health and care services • Digital solutions to save clinical and administrative time	Integrated Commissioning Framework	TBC

Personalised Care

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Language/Interpretation Service – We will be commissioning a new model of service as part of the navigation work for the Networks	Homerton Hospital	The Current CHS Bi-lingual Advocacy Service will be commissioned differently in partnership with stakeholders to deliver better navigation across networks	• Improved patient equity • Better reporting of activity • Improved service for vulnerable patients • Financial saving • Improved efficiency	Inequitable access primary care Poor service reporting	Agree approach Sep 2019 Agree specification Jan 2020
Review the results of the Personal Health Budget pilot and determine how PHBs are recurrently funded across the system.	East London Foundation Trust	Comprehensive City and Hackney PHB offer.	a) Compliance with national PHB targets	The NHS Long Term Plan	Evaluation – April 2020 tbc
	Adult Social Care Service (London Borough of Hackney & the City of London)		b) Greater service user autonomy and choice	The NHS Mandate	
	Voluntary, community and social enterprise sector		c) Greater support for people with more severe mental health problems.	Extending legal rights to personal health budgets and integrated personal budgets: consultation response (Department of Health and Social Care, and NHS England)	
			d) Incentives to service users to improve mental and physical health.	City and Hackney Joint Mental Health Strategy	

Prescribing

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Anticoagulation • Adherence to the service specification for anticoagulation • A requirement that any patients initiated on DOACs outside of the haematology clinic should be referred to the primary care anticoagulation service for follow up and not to the Homerton Hospitals clinic • Joint working with the CCG and primary care anticoagulation service to develop pathway update for anticoagulation and DOAC transfer of care information in place of current SCGs. • Transfer of care document to incorporate recommendations from the London-wide GP toolkit for initiating DOACs (to be published) • Virtual anticoagulation clinic, see example: https://www.southwarkccg.nhs.uk/news-and-publications/news/Pages/virtual-clinics-help-cut-stroke-rates.aspx	Homerton Hospital	• Participation from anticoagulation team • Change in the process for managing oral anticoagulants at Homerton Hospitals	• Improved patient safety due to timely review of patients • Improved efficiency and seamless process for managing patients who are prescribed oral anticoagulants • Cost-saving as less costly for patients to be seen in primary care • More convenient for patients as they don't need to go to the hospital for follow-up • Free-up time for secondary care clinicians to see more complex patients	Service specification for anticoagulation	
Supporting patients in taking their medicines at home. • Participating in the development of an integrated medicines strategy and policies for health and social care • No services are to request support for patients regarding medication at home unless an individual patient assessment has been undertaken using a validated tool. This is to avoid the high number of requests for medicines to be supplied in 'blister packs' without any patient assessment • Requirement for all services to adhere to the local guidance on the use of medicines compliance aids • To incorporate the use of MaPPs in patient discharge counselling	Homerton Hospital	• Participation from community health services, allied professional and Homerton Hospitals pharmacy team • Change in the process for assessing patients for ability to use their medicines and counselling patients at the point of discharge	• Integrated care - more holistic approach • Patients are appropriately assessed to see if they are able to manage their medicines rather than routinely issuing blister packs which may not be appropriate • Appropriate patient counselling which may improve patient adherence to medicines • Improved patient safety		
DMARDs Support with developing a more robust SCG process for DMARDs, in particular: • IT infrastructure support to aid better communication for agreements for shared care. Pathology results for DMARD monitoring to be transferred to EMIS to aid safe prescribing of repeat prescription. Currently results from Homerton Hospitals need to be viewed from HIE (Cerner portal) which is slow to load and does not interact with EMIS alerting system for drug monitoring.	Homerton Hospital	• Participation from clinical teams and pathology • Change in the process of reporting blood results • May require an update to current IT system	• Seamless process for managing patients who are prescribed high risk drugs • Improved patient safety • Improved efficiency	Current system risky and patients are prescribed DMARDs by their GP but have their blood monitored by the hospital	SCGs for DMARDs have been updated in the last 2 years
Continence products • AICS to take over supply of continence products in 2020 and ensure that the prescribing of continence items is in line with the new formulary • AICS to hold details of all C&H patients using continence items and to be able to intervene if any problems identified with prescription requests • Quality service improvements such as all patients being given a 'catheter passport'	Homerton Hospital	• Participation from the AICS team • Updates to IT system Staff time / roles AICS will need to seek funding to produce the catheter passport	• Better process for managing patients prescribed incontinence products • Potential cost-saving due to appropriate prescribing of formulary choice products and reduced wastage • More convenient for patients due to having single point of contact		
Dietetic services • Engagement by the service for review of joint local guidelines pertaining to feeds • Clarity to prescribers on how individual patients initiated on ONS should be monitored (including frequency) and when treatment should be stopped • Provide clear rationale to primary care prescribers when recommending ONS that are outside of the City and Hackney preferred list • Education and training on appropriate prescribing and review of ONS • Advice and guidance system set up for dietetic queries • Business case for dedicated dietetic support to City and Hackney practices to deliver focused 2020/21 work plan to reduce inappropriate and costly prescribing of ONS across the borough	Homerton Hospital	• Participation from community dietetic team • Change in practice for community dieticians	• Potential cost saving if ONS prescribed, monitored and discontinued appropriately • Better communication between community dietetic team and primary care prescribers • Improved efficiency - if GPs can get advice re dietetic queries via advice and guidance rather than having to send all patients to the dietetic clinic		

Prescribing Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Transforming hospital pharmacy services • Appropriate processes in place in order to implement recommendations from Lord Carter's and NHS England's reports. • Present information relating to implementation of these reports quarterly to MOPC • Prioritise all patients admitted through urgent and emergency routes, high risk patients and patients requiring discharge on weekends to receive an appropriate clinical pharmacy medication review promptly • At least 70% of patients admitted have medicines reconciliation done in line criteria from the NHSE medicines optimisation dashboard	Homerton Hospital	• Participation from Homerton Hospitals pharmacy team and the wider team • Staff time / roles • Change in the way Homerton Hospitals reports medicines reconciliation	• Improved patient safety • Assurance of safe practice at Homerton Hospitals • Smooth transition of care between secondary and primary care • Instils confidence in the public re standards of local hospital pharmacy • In line with national (Lord Carter's) recommendations to NHS hospitals • Enables benchmarking with other hospital providers	• Lord Carter's and NHS England's reports • NHSE medicines optimisation dashboard	
Formulary management • Ensure new drug applications are submitted in time, are sufficiently robust and have had input from the Trust's pharmacy team. • Engage in regular review of BNF chapters, including actively looking to decommission drugs no longer offering benefit and completion of formulary applications for new medications • Development/update and supporting launch of medicines related pathways and guidelines • Ensure documents highlighted by the JPG (e.g. NHSE and RMOC) reaches and is actioned by appropriate clinicians at Homerton Hospitals. • Work with relevant commissioner(s) when contracts are negotiated for the procurement or supply of items which may require ongoing prescribing/ supply in primary care (including wound care products, incontinence and stoma products, glucose monitoring devices/machines/strips and feeds) • Work with the CCG in addressing areas where the CCG prescribing profile shows significant variation to comparator CCGs • Provide a business case to the JPG for the use of botulinum toxins in conditions other than migraine and overactive bladder syndrome • Take active steps to address non-adherence to the formulary when notified by the CCG. • Improving staff awareness and knowledge about the joint formulary encouragement by Homerton Hospitals pharmacists to all relevant staff re: need to adhere to the formulary Joint working between Homerton Hospitals pharmacy team and JPG to help raise awareness and promote adherence to the joint formulary for all members of staff • Ensure the JPG is consulted on any changes that Homerton Hospitals makes to the hospital supply of items that will need to be continued in primary care (e.g. thickening powder) • Ensure staff are made aware of Homerton Hospitals' policy for joint working with pharmaceutical industry	Homerton Hospital	• Participation from Homerton Hospitals pharmacy and all staff involved in prescribing/ recommending medicines and medicines-related products • Change in the process of prescribing for some staff • Collaborative working with stakeholders • Change in the way staff interact with pharmaceutical industry	• Evidence based and cost effective use of medicines (in line with local and national recommendations) • May reduce expenditure for drugs and medicines-related products • Improved patient safety • Improved staff awareness of the formulary • Assurance that decisions made by secondary care clinicians are un-biased and not influenced by the pharmaceutical industry • Instils confidence in the public • Assurance that both secondary and primary care follow the same process for prescribing (i.e. hospital not making recommendation for non-formulary medicines that could not be continued in primary care).	• NICE MPG1 - Developing and updating local formularies • JPG Terms of Reference	• Draft Homerton Hospitals Joint Working policy with Pharmaceutical Industry about to be approved • Increased involvement from Homerton Hospitals clinicians and pharmacy team in new drug submissions to the JPG
Antimicrobial resistance (AMR) • Key clinicians and pharmacists to actively work towards reduction in antimicrobial usage across the primary-secondary care interface • Support and direction from Homerton Hospitals microbiology team (including pharmacy) to tackle national target to reduce gram negative bloodstream infections in City and Hackney • Long term UTI prophylaxis - Homerton Hospitals to work with City and Hackney CCG to develop a primary care audit to review whether patients who have been put an antibiotic for UTI prophylaxis have the antibiotic prescribed, reviewed and monitored appropriately.	Homerton Hospital	• Participation from microbiology team and Homerton Hospitals antimicrobial pharmacist	• Reduced antimicrobial resistance and gram negative blood stream infections • Reduced risk of patients suffering side effects associated with long term use of antibiotics • Safeguarding antibiotics for future generations	• Tackling antimicrobial resistance 2019–2024: The UK's five-year national action plan	

Prescribing Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
Discharge to pharmacy (renamed as Transfer of Care Around Medicines) System to be rolled out during 2020/21 in line with agreed plan to all wards where patient benefit is anticipated. Rollout to be completed by March 2021	Homerton Hospitals	• Participation from Homerton Hospitals pharmacy team and wards • Updates to current IT system	• Improved communication between secondary care and community pharmacies for seamless management of patients' medicines at the point of discharge • Improved patient safety • Improved efficiency of discharges • Cost avoidance re delayed discharges, incorrect drug histories • Free-up beds for other patients	• Process being rolled out at Whipps Cross hospital •Similar schemes in Newcastle:- http://bmjopen.bmj.com/content/6/10/e012532.full & East Lancs Youtube https://youtu.be/V-FNeOFcvEw	Roll out of system in 2020/21
Engagement in partnership working • Active participation of the trust's Pharmacy team at the JPG and MOPC, with submission of papers (including but not limited to prescribing related audits undertaken, incident reports, benchmarking data/reports) ahead of meetings and discussion at the meetings • To highlight the need for pharmacy representatives at MOPC to take on the tasks of representing and when appropriate, inviting relevant clinicians regarding issues raised at MOPC. This should include reviewing the agenda and ensuring the correct persons is present to represent the Trust and make decisions for relevant agenda items.	Homerton Hospitals	• Commitment from senior pharmacy staff at Homerton Hospitals	• Homerton Hospitals to have an oversight of what is happening in terms of prescribing in primary care for purpose of improving patient care • MOPC would benefit from un-biased / non-conflicted opinions from Homerton Hospitals pharmacists for primary care agenda items • Some of the topics discussed at MOPC would require input from secondary care e.g. NRLS reporting, new service development, clinical audits	• JPG and MOPC Terms of Reference	• Good attendance from Homerton Hospitals senior pharmacists at JPG and MOPC meetings
Discharge planning • Improve IT systems to ensure brand names are included in eTTAs for drugs where brand name prescribing is essential • Clear endorsement on eTTAs with information on which medicines have been started, stopped, dose amended with clear rationale and clear monitoring information • Minimum supply of 2 weeks of medicines post discharge unless intended course is shorter than this period • Highlight to GP practices any patients who would benefit from a post discharge home medication review. Actively refer patients who would benefit from a review by the community pharmacy under NMS or MUR (all patients admitted with stroke/TIA) must be referred. • Homerton Hospitals pharmacy department to work towards developing a system for engagement with appropriate pharmacists in primary care to ensure seamless transfer of medication optimisation across the interface. This should include, where relevant communication with community pharmacies, primary care network pharmacists/practice-based pharmacists	Homerton Hospitals	• Participation from Homerton Hospitals pharmacy team and prescribers (particularly junior doctors) • May require updates to current IT system	• Improved patient safety • Improved efficiency • Aids medicines reconciliation post discharge • Assurance that patients have enough supply of new and regular medicines at the point of discharge • Better communication between Homerton Hospitals pharmacy team and pharmacists in the community		

Prescribing Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
PbR-excluded (high cost drugs) • Notifications / prior approval and individual funding requests (IFR) must be submitted before starting treatment. Application for re-approval of PbR excluded drugs if the trust wishes for treatment to continue. Initiation form required for all patients initiated on or after 01/01/2015 and continuation form required for all patients initiated on or after 01/04/2017.	Homerton Hospital	• Participation from Homerton Hospitals pharmacy team (particularly pharmacists leading on HCDs), finance team and relevant clinicians • Requires ongoing funding for the lead biologic pharmacist to facilitate this work	• Assurance that the CCG is funding HCDs for patients who are eligible • Reduced challenges for the Trust • Cost avoidance for Homerton Hospitals (i.e. reduced the risk of the trust absorbing the cost of HCDs where funding is declined by the CCG due to patients not meeting funding criteria)	• SLAM dataset • NICE guidelines (for initiating and reviewing treatment for relevant conditions)	• Good communication between Trust clinicians, Trust lead biologic pharmacist and the CCG re:- issues relating to HCDs • Homerton Hospitals completed a continuation audit for HCDs used in dermatology, gastroenterology and rheumatology
Uptake of Biosimilars • Pharmacy department to: a. support specialist teams in the uptake of biosimilar products as they become available b. Have policies in place to facilitate & enable clinicians to make clinically and cost effective choices in prescribing biological medicines. • Communication and implementation plan in place to alert prescribers to new and to better value biological and biosimilar medicines that become available, and engage patients affected. • Lead (biologics) pharmacist to link in with the relevant national/ regional leads/contacts to support Trust staff in delivering timely change	Homerton Hospital	• Participation from Homerton Hospitals pharmacy team (particularly pharmacists leading on HCDs) and relevant clinicians • Ongoing lead biologic pharmacist to facilitate this work	• Cost saving locally and nationally as Biosimilars are more cost effective than the reference drugs. • Potential to use the money saved to invest in services/staff to improve patient care	• NHSE Commissioning framework for biological medicines	• Improved uptake of biosimilar medicines at Homerton Hospitals
Bone Health • Homerton Hospitals to work with City and Hackney CCG to develop a primary care audit to review whether patients with previous fragility fractures have bone health assessment done and are prescribed the appropriate bone protection medicines.	Homerton Hospital	• Participation from the relevant clinical team to review the audit criteria and results and to follow up on any recommendations	• Improved management of patients with fragility fracture • Potential cost saving (reduced hospital admissions for fractures)	Request from the bone health working group for City & Hackney CCG to carry out this audit	
Hypertension medicines adherence: designing the approach	GP Confederation	Potential for targeted approach to helping residents adhere to their hypertension medications e.g. through pharmacy reviews and peer support	Improved adherence will lead to reduction in complications and improved health outcomes such as reduced strokes and cardiovascular events	Medicines compliance is problematic in hypertension. This work will aim to establish whether culturally specific approaches and non-traditional interventions would be effective in improving this.	Audit by medicines management team
	? Voluntary sector				Resident engagement events
					Design approach
					Implement project

Primary Care & PCN

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
FIT Testing (Continuation and full impact of test) FIT Testing will reduce the need for GP referred DAF and DAC services	Homerton Hospital /Barts Hospitals	• Reduce the number GP referrals for Flex Sigmoidoscopies and Colonoscopies.	• Less invasive diagnostic for patients • Financial Saving	NICE Guidance	Not applicable as all elements in place
FIT testing for National Bowel Cancer Screening - NHS England rolling out FIT testing for the screening programme - we need to ensure our contracts reflect the new testing and primary care support patients with the new screening programme	Confederation Cancer Services, Primary care	• Reduces referrals to secondary care for diagnostics. • Supports Bowel Screening Target	• Improve screening take up • Age screening reduced to 50	Long Term Plan	• Sep 2019 implementation • Local awareness campaign
Increasing cancer awareness - Project implementation to improve screening awareness	Primary Care and Secondary care	• Raise awareness of cancer symptoms with a focus of gastro intestinal cancers	• Earlier diagnosis • Better outcomes		• Contract placement - Oct 19 • Impact 2020

Maternity

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
• **Continue to roll out the 'Saving Babies Lives Care Bundle' and continue to maintain our focus on reducing infant mortality and avoidable admissions to NICU.** • **Build on our strong trajectory in continuity of carer implementation, through the HUFT CQUIN for diabetic women**	Homerton Hospitals/ Out of Area Providers where appropriate (as per implementation of women's choice of maternity provider)	Reduction on infant mortality and avoidable admissions to NICU.	Quality improvements in service delivery	NICE Guidance/ National Maternal and Neonatal Health Safety Collaborative	50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025 Most women receive continuity of the person caring for them during pregnancy, during birth and postnatal by March 2021l .
• **Agree clear long-term pathways to support women to access OTC and prescription medicines throughout the antenatal and post-natal periods**	Homerton Hospitals/ Out of Area Providers where appropriate (as per implementation of women's choice of maternity provider)		Quality improvements in service delivery		
• **Focus on implementing the new smoking in pregnancy pathway**	Homerton Hospitals/ Out of Area Providers where appropriate (as per implementation of women's choice of maternity provider)		Quality improvements in service delivery		
• **Focussed early support, and a clear pathway for our most vulnerable women in their pregnancies, through enhanced checks and education** • **Commission pre-conception checks for women with Long Term Conditions, and enhanced pregnancy presentations and post-natal checks**	Homerton Hospitals/ Out of Area Providers where appropriate (as per implementation of women's choice of maternity provider)		Quality improvements in service delivery		
• **Continue to commission our VCS providers to deliver antenatal support for our most vulnerable women**	Voluntary and Community Sector /Hackney CVS		Quality improvements in service delivery		
• **implement digital solutions to support working better with patients, including maternity digital care records, digital child health information ('e-red book') records, and development of an app to support pregnant women to navigate our services**	Primary and Secondary care		Quality improvements in service delivery		

Children and Young People

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
• **Continuing to develop and embed partnership arrangements to deliver Transforming Care and preventing the avoidable admission of CYP with autism and / or LD**	Secondary care /The Local Integrated Partnership / System	System wide approach to identification, joint working	Quality improvements and the implementation of clear processes for delivery of CTERs (Care, Treatment and Education reviews), across the system.	LTP	.
• **Review the total Speech and Language Therapy budget against the level of need across City and Hackney**	In collaboration with health, education and social care partners including Hackney Council, City of London Corporation	The development of an integrated commissioning framework and service model for CYP SaLT provision in City and Hackney, underpinned by pooled budgets	Quality improvements in service delivery	LTP	
• **Implement recommendations arising from the review of lead professional and key working roles for children with complex needs, in line with the LTP recommendations**	Homerton Hospitals		Quality improvements in service delivery	LTP	
• **Review the impact of the community paediatricians to the audiology Tier 2 service, and mobilise the reconfigured child health clinics across agreed general practices.**	Homerton Hospitals/		Quality improvements in service delivery	LTP	
• **Initiate joint reviews for Occupational Therapy, and explore reviewing the commissioning of Learning Disability across the partnership**	Voluntary and Community Sector /Hackney CVS		Quality improvements in service delivery	LTP	
• **Commission a sickle cell mentoring scheme across the STP**	Primary and Secondary care		Quality improvements in service delivery	LTP	
• **Continue to work with partners to implement the 'Working Together' guidance, putting in place the new statutory NEL child death review transformation plan**	Homerton Hospitals, NEL/STP		Quality improvements in service delivery	LTP	

Children and Young People Cont.

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
• **Continue to drive the implementation of the NEL CSA Hub (Child sexual abuse multi-agency support hub).**	Homerton Hospitals, NEL/STP		Quality improvements in service delivery	LTP	
• **Recommission the Early Years' service recognising the reduction in available funding, and work to develop the coding of CYP with complex needs and including autism, ASD, and LD.**			Quality improvements in service delivery	LTP	
• **Improve childhood immunisation coverage and childhood flu**	Neighbourhood Health and Care and Primary Care		Quality improvements in service delivery	LTP	
• **Review the opportunity to integrate our VCS KIDS and Huddleston short breaks services with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme.**	Voluntary and Community Sector /Hackney CVS		Quality improvements in service delivery	LTP	
• **Continue to commission our strong Health Visiting, School Based health (school nursing) and Family Nurse Partnership services.**	Public Health commissioned providers (HUFT, Wittington Health, Voluntary and Community Sector /Hackney CVS and Young Hackney)	A joint service would likely be commissioned to start in the 2021/22 financial year	Quality improvements in service delivery	LTP	
Linked to the Prevention work: • **The CYP physical activity services are being redesigned and aligned to other physical activity services in the Council** • **The current SLA for the Young Hackney Substance Misuse Service expires in October 2020, in line with the adult's substance misuse service. As part of the scoping for the design of both the adults and CYP substance misuse services, it was decided that the adults and CYP service would remain separate.**		Redesign of The CYP service over the next year	Quality improvements in service delivery	LTP	

Child and Adolescent Mental Health

Activity	Which provider will this impact	How will they be impacted/ affected	Outcomes / the difference it will make	Any supporting data / evidence	Key milestones
• **Development of 24/7 Crisis pathway for CYP and agreeing models for delivery. (Funding is expected to come from NHSE Tier 4 beds savings)**	East London Foundation Trust, as part of NEL/ STP arrangements	To align with the New Models of Care. To explore increasing the age range of the CRHT in line with the Gloucester model	• Quality improvements in service delivery • Improving mental health up to the age of 25.	Gloucester model of crisis service	
• **Create a single point of access and a work toward a fully integrated Tier 3 CAMHS service (including CAMHS disability services) working as a single integrated team.** • **Develop a comprehensive 18-25 Transitions service (Tier 2 and Tier 3) in line with national requirements.** • **Develop an improved offer for the mental health of very young children (0-5) and their parents which incorporates work from the ACEs project team** • **Continue to roll out our Wellbeing and Mental health in schools work (WAMHS) to all state maintained schools and develop a similar offer to state registered Independent schools that have a majority City and Hackney population. This will be supported by the development of NHSE funded Mental Health in Schools Teams from September 2019** • **Improve MHSDS outcome reporting that reflect accurately the work being done** • **Clinical Pathway Optimisation: based on the up and coming Demand vs Capacity review of all our CAMHS pathways work collaboratively to deliver the output / recommendations.** • **Reviewing our Youth Justice Pathway Early Help and Diversion pathways, with our partners across the system** • **Maximise our digital capability through implementation of an integrated patient journey management system across CAMHS services. This will include Investment in analytics support to CAMHS and investment in the development of the CAMHs website to support patients and their families.**	East London Foundation Trust and Homerton University Hospital Foundation Trust (with CAMHS Alliance partners)		• Quality improvements in service delivery • Improving mental health up to the age of 25 • Patients and their families will feel supported.		
• **Improve the mental health of Black African and Caribbean heritage young people at key transition points.** • **Continue to commission the delivery of our VCS pilot 18-25 year old transition service**	Voluntary and Community Sector /Hackney CVS		• Improving mental health up to the age of 25		

ANNEX B

DRAFT 2020 - 21 CITY AND HACKNEY SYSTEM INTENTIONS

Summary version

Version 3 – 20/09/19

NHS
City and Hackney
Clinical Commissioning Group

NHS
East London
NHS Foundation Trust

City of London

City & Hackney
GP Confederation
A community interest company

NHS
Homerton
University Hospital
NHS Foundation Trust

Hackney

PLANNED CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :

- Community services transformation in Neighbourhood Health and Care for people with long term conditions.
- Transformation of Outpatient services at Homerton.
- Support the mental health and well being strategy; improve opportunities for access to housing for vulnerable and disadvantaged groups; drive an integrated strategy for people with learning disabilities with a strong focus on prevention and reducing inequalities.

Outpatient Transformation

- Virtual clinics for first appointments and follow ups
- Pathway development
- Digital innovation
- Self management support

Personalised care and coproduction

- Ensure coproduction is in place throughout the workstream activities involving residents service users, carers and staff at all levels
- Development of the cross cutting cultural change to support personalised care in our services
- Development of infrastructure to support choice and control across health and social care
- Increase uptake of Personal health budgets (PHBS) and direct payments
- Development of a specific PHB offer to people with learning disability to support new strategy

Neighbourhood health and care services

Supporting the development of the provider alliance to deliver integrated community services at the neighbourhood/network Including:

- Community gynaecology and women's health service
- Community ENT
- Respiratory – integrated community consultant offer increased capacity for pulmonary rehab, early identification, medication support and peer support
- Renal – community consultant input
- Community dialysis
- Community diabetes
- Heart failure service for IV diuretic
- Stroke – recovery and rehabilitation support

- Support the ACN service and the core neighbourhood team in delivery of CHC
- Development of specialist skills and increased capacity – e.g. MH and neuro pathways

Mental Health

- Mental Health neighbourhood transformation programme
- The Provider Alliance
- MDT model for physical and mental health interface

Housing and Accommodation services

- Implement Housing Frist
- Redesign of high needs residential services with ELFT
- Strengthen CHC offer for adult mental health
- Review the role of the ELFT rehabilitation team and if the model could be expanded to support people with Learning Disability returning to local services

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Children and Young People (with the CYP Workstream)

- Strengthen our approach to Care and Treatment Reviews and interventions for children and young people with a learning disability or autism – supported by our Darzi fellow

Prescribing

Medicine Optimisation

- Improving transfer of about medicines at hospital discharge
- Pathway updates for anticoagulation

Primary care and primary care networks

- Peer review and audit of referrals by practices
- Network involvement in development of and delivery by the Provider alliance
- Education and support to maintain early diagnosis of cancer and provision of services for cancer survivors for follow up care, screening access and awareness
- Physical health checks and action plans for people with a learning disability

Continuing Healthcare (CHC)

- Continued improvement of local delivery
- Partnership strategic planning for local nursing home provision and funding arrangements
- Implementation of NEL review

Services for people with Learning Disabilities

- ILDS service transformation
- C&H strategy for people with learning disabilities
- Transforming Care Programme (TCP) and Long term plan
- Physical health
- Cost and implement the strategy with a focus on prevention
- Increasing access to mainstream services and asking partners to ensure reasonable adjustments for people with learning disability and autism
- Strengthen our preventative approach in our TCP

Long term conditions (with prevention Workstream)

- Secondary prevention and services supporting people in the community
- Cancer – Early Diagnosis, Faster Diagnosis standard, screening awareness and supporting people in recovery

North East London- System Transformation Priorities:

- Integrated care system development; Outpatients transformation; Surgical redesign

UNPLANNED CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :
Bring together partners to create services that meet people's urgent needs and support them to stay well

GSC 2021

Integrated Urgent Care

- Implementation of effective out of hours primary care services - 111, extended access hubs, GP OOH
- Implementation of streaming and redirection model at the front door of A&E
- Maximise use of appropriate care pathways (Paradoc, IIT, MH crisis line) working with LAS and primary care
- Improvements and enhancements to falls pathway
- Implement actions from the Duty doctor review
- Review of ambulatory care services
- Engage with the public to increase awareness of urgent care services
- Ongoing roll out and realise benefits from CMC care plans - including introduction of My CMC
- Working with public health to support procurement and implementation of a new substance mis-use service
- Progress blended payment - the new tariff for emergency hospital care

Neighbourhood

Supporting the development of the provider alliance to deliver integrated community services at the neighbourhood/network Including:

- Development of the anticipatory care service as part of the neighbourhood model, including the development of a core integrated team around each neighbourhood and an effective model of navigation
- Transformation of adult community nursing and adult community therapies

Establishment of a model for how the neighbourhood structure provides a framework for effective involvement from the voluntary and wider community sector

Work with partners to maximise the potential that neighbourhood working brings to address the wider determinants

Improve Patient flow and Discharge Pathway

- Delivery of DToC case notes audit action plan.
- Review and implement a sustainable discharge to assess (or other) model.
- Improved primary care and wider system support to our local care home residents
- Review of Intermediate care services and interim care bed provision
- Better pathways for homeless people coming out of hospital.
- Improved support to local care homes, and improved working between care homes and hospitals - including introduction of trusted assessor and red bag scheme

Mental Health

- Development of High Intensity Service User service for frequent users of A&E, 111, LAS based on the results of the pilot
- The expansion of alternatives to crisis
- Embedding the community dementia service within the neighbourhood model and greater integration with adult social care

End of life care

- Implementation of new Urgent end of life care service
- Better support at end of life for homeless people, working with local hostels

Strategic Priorities

- Develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- Provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information
- Develop urgent care services that provide holistic, consistent, care and support people until they are settled
- Work together to prevent avoidable emergency attendances and admissions to hospital
- Provide timely access to urgent care services when needed, including at discharge
- Deliver models of care that support sustainability for the City and Hackney health and care system.

CHILDREN, YOUNG PEOPLE, MATERNITY AND FAMILIES CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :

Continue to work to give our children and families the 'best start in life' (LTP 2019) including commissioning high quality services, that maximise health and wellbeing outcomes for families throughout the early part of the life course

Children and Young People

- Continue to develop and embed partnership arrangements to deliver Transforming Care and preventing the avoidable admission of CYP with autism and / or LD who display challenging behaviour to specialist inpatient hospitals
- Development of an integrated commissioning framework and service model for CYP SaLT provision
- Continue the development of monitoring and review processes to support the delivery of SEND requirements
- Mobilise the reconfigured child health clinics across agreed general practices.
- Initiate joint reviews for Occupational Therapy, and explore reviewing the commissioning of Learning Disability across the partnership
- Commission a sickle cell mentoring scheme across the STP
- Recommission the Early Years' service recognising the reduction in available funding, and work to develop the coding of CYP with complex needs and including autism, ASD, and LD.
- Continue to commission our strong Health Visiting, School Based health (school nursing) and Family Nurse Partnership services.
- Redesign the CYP physical activity services
- Commission the redesigned Young Hackney Substance Misuse Service over the next year.

Maternity

- Continue to focus on quality improvements in service delivery,
- Accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025
- Build on our strong trajectory in continuity of carer implementation
- Support women to access OTC and prescription medicines throughout the antenatal and post-natal periods
- Improve women's experiences of maternity care
- Collaborate with the Prevention workstream to focus on implementing the new smoking in pregnancy pathway, and support the development of the MECC programme

Integrated Service model

- Implement an integrated service model for the health assessment, caseload management and nursing provision for looked after children placed by / in City and Hackney, and a comprehensive health offer for care leavers up to the age of 25.
- Create a single point of access and a work toward a fully integrated Tier 3 CAMHS service (including CAMHS disability services)

Improve immunisation coverage

- Continue to work with the GPC and system partners to improve childhood immunisation coverage and childhood flu, utilizing the developing neighbourhood and Primary Care network structures
- Promote the offer of the flu vaccination and pertussis for expectant mothers

Child and Adolescent Mental Health

- Development of 24/7 Crisis pathway for CYP and agreeing models for delivery
- Development of a comprehensive 18-25 Transitions service (Tier 2 and Tier 3) in line with national requirements
- Development of an improved offer for the mental health of very young children (0-5) and their parents which incorporates work from the ACEs project team.
- Continue to roll out our Wellbeing and Mental health in schools work (WAMHS) to all state maintained schools and develop a similar offer to state registered Independent schools that have a majority City and Hackney population

Digital innovation

- Maximise our digital capability through implementation of an integrated patient journey management system across CAMHS services.

Working with our VCS partners

- Continue to review the opportunity to integrate our VCS KIDS and Huddleston short breaks services with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme
- Continue to commission our VCS providers to deliver antenatal support for our most vulnerable women
- Continue to review the opportunity to integrate our VCS KIDS and Huddleston short breaks services with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme.
- Deliver work to improve the mental health of Black African and Caribbean heritage young people at key transition points. We will be supporting our partners to deliver this from late 2019.
- Continue to commission the delivery of our VCS pilot 18-25 year old transition service

PREVENTION WORKSTREAM : 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective:

- Reduce the harms from the 10 most preventable causes of poor health.
- Take early action to avoid or delay future poor health.
- Support and enable people to take control of their own physical and mental wellbeing.

Long term conditions - earlier intervention

- Start work to refocus the Long Term Conditions (LTC) contract with the GP Confederation to have a stronger emphasis on incentivising prevention.
- Areas identified with potential to include/enhance incentives for: alcohol screening and brief advice; reducing variation in referral rates to stop smoking services; COPD and asthma prevalence/case finding; group consultations and self-management; identifying and improving access to support for carers (including linking in to new carer support services in Hackney and the City); implementing annual reviews for other conditions (epilepsy, sickle cell); amongst other things.
- Another opportunity identified is the integration of the NHS Health Check contract within the LTC contract to optimise and align incentives for cardiovascular disease (CVD) prevention in primary care.

Rough Sleepers

- Use the learning from various local pilots currently underway/planned to inform the development of effective care pathways for rough sleepers in Hackney and the City.

Supporting people to take control of their own health and wellbeing

- Re-commission the existing Social Prescribing service to integrate fully with new funded Primary Care Network provision and align with the new Neighbourhood community navigation model.
- Improve access to, and awareness of, local prevention services using the learning from two digital pilot projects (Digital Social Prescribing Platform and Directory of Services).
- Use the learning from the 'three conversations' innovation site to embed a strengths-based, preventative approach across social care practice in Hackney.

Sexual Health

- Work with the Planned Care Workstream to develop a collaborative approach to commissioning women's sexual and reproductive health services.

Learning disability and prevention

Collaborative working with Planned Care colleagues to implement actions on prevention as set out in the new City and Hackney Learning Disability Strategy with focus on

- Increasing access to mainstream services and asking partners to ensure reasonable adjustments for people with learning disability and autism

Obesity

Collaborative working to tackle obesity locally will continue through a new 10 year strategic 'healthy weight' framework, which has been co-produced with a broad alliance of partners.

Planned Care Workstream

- Commission a new weight management service to meet the needs of people with complex needs who are not eligible/suitable for bariatric surgery.

CYPMF Care Workstream

- Undertake a review of the child obesity pathway, with a focus on complex needs provision.

Alcohol, Substance Misuse and Tobacco Dependency

- Embed tobacco &alcohol screening and brief advice targets as service KPIs from 2020/21.
- Complete the re-procurement of a new integrated City and Hackney adult substance misuse service.
- Collaborate with North East London partners, working in partnership with Homerton and ELFT, to develop a business case to implement the Ottawa inpatient model of bedside support to quit smoking.

Mental Health

- Design a new service offer to better support a targeted preventative approach to improving mental wellbeing, informed by the new City and Hackney Mental Health Strategy and the findings of an evaluation of the Wellbeing Network
- Continue to work with local VCSE and statutory providers to improve the offer of supported employment provision for people with mental illness, learning disabilities and other support needs

Making every contact count (MECC)

- Embed MECC principles in health and care service provision through appropriate contractual levers, to support the sustainability of our approach to system-wide action on prevention.

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