Keeping people well in City and Hackney

Our local strategic delivery plan and NHS Long Term Plan response

Summary version

Version 1.5

Hackney

CITY OF LONDON

NHS
City and Hackney
Clinical Commissioning Group

Our local strategic delivery plan and NHS Long Term Plan response

This document summarises how the City and Hackney system (one of three place-based systems within the East London Health and Care Partnership STP) will 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.

This plan has been drafted in collaboration with local partners through the City and Hackney system's integrated commissioning programme. It reflects the principles set out in the Long Term Plan implementation framework:

- **It is clinically led** through the integrated commissioning programme in City and Hackney which includes senior clinical leadership on all care workstreams and transformation programmes. The City and Hackney system is characterised by a strong history of primary care leadership in relation to quality improvement, admissions avoidance and our neighbourhoods programme, and the new clinical directors of our primary care networks will lead implementation of integrated care.

- From our Outcomes Framework to our ambitious Neighbourhoods Programme, City and Hackney's system **ambitions are locally owned** and have been co-designed and co-produced with local residents and service users. In considering our response to the NHS Long Term Plan we have held 23 events, 3 surveys, 2 focus groups, and a small number of 1-to-1 interviews 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.

- Whilst City and Hackney is one of three subsystems within the East London STP area, the local system is **financially balanced** and transformation programmes are focused on ensuring that services and systems remain financially sustainable in the context of future patterns of population change and increasing demand. Whilst a national funding settlement has been agreed in relation to the NHS Long Term Plan, our system continues to face challenges in how social care is resourced and we expect further clarity in planning once the social care Green Paper is published.

- Whilst many elements of the Long Term Plan will be delivered at integrated care system (ICS) level (i.e. across the whole of North East London), this document summarises how the City and Hackney system will locally **deliver the commitments in the LTP and national access standards**. Our local system is high-performing against national access targets for cancer treatment, mental health and A&E, and we are continuing to improve access such as with our successful bid to develop new community care models in mental health. The CCG was recently rated 'Outstanding' against the Improvement and Assessment Framework.

- We have been clear about locally identified priorities in relation to known **local needs**, and the plan will be developed to show the **phased approaches** in our transformation programmes to delivering these local priorities over time.

- The City and Hackney system welcomes the focus in the NHS Long Term Plan on **reducing local health inequalities and unwarranted variation** as this underpins our local transformation work, particularly our whole-system focus on targeting local areas of continued deprivation such as work in Hackney Wick to address the wider determinants of health. The NHS Long Term Plan provides a road map for improving care quality and outcomes by delivering a strong start in life for children and young people and better care for major health conditions.

- Well-established integrated commissioning structures in City and Hackney have ensured that **prevention** has been made central to all our programmes of work, from Making Every Contact Count, to our mature and ongoing delivery of social prescribing in every GP practice.

- The City and Hackney system is governed by our integrated commissioning boards which reflect **our close integration with the two local authorities.** This includes system appointments to key roles from local authority staff, integrated commissioning and pooled budgets in many areas, such as the Integrated Independence Team for reablement, and combined work programmes which reflect a focus on health and wellbeing throughout our community strategies.

- 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 through our Neighbourhoods Programme.

- Our plans build on past successes and outline our future ambition to improve the quality of care and harness the skills and talents of our staff and residents to deliver this work. This system-wide approach will ensure we become an exemplar for high quality, safe and reliable care.

There will be one response to the NHS Long Term Plan for North East London, which is being drafted by East London Health and Care Partnership. This summary describes the City and Hackney contribution, but **it is the ELHCP document which will be formally submitted to NHS England on September 28th 2019.**

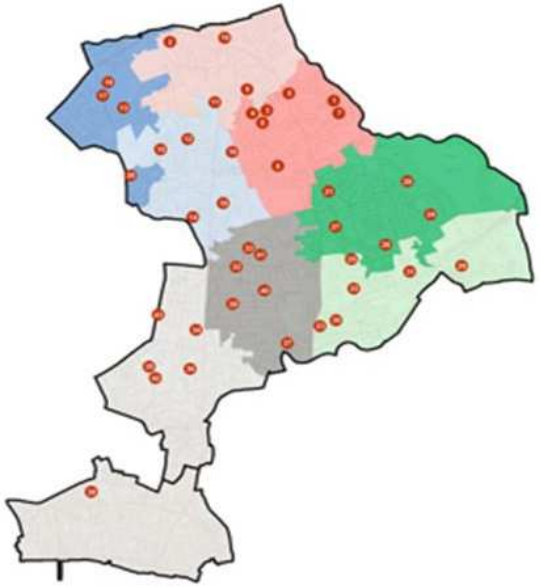
The challenges in City and Hackney in relation to peoples' health

We cover an area of North East London made up of the City of London and the London Borough of Hackney. Our total population is 283,600. Hackney has 275,900 residents, the City has 7,700. We have 322,616 people currently registered with a local GP practice. Our population has been growing faster in recent years than in other parts of England. While the City has a low permanent-resident population compared to other areas, more than 400,000 people travel to work here every weekday. Our area is one of the most diverse in the country, with nearly 90 languages spoken as a main language.

City and Hackney faces significant health and wellbeing challenges. Despite economic growth and regeneration in recent years, Hackney still has some deeply deprived areas and high levels of child poverty, which varies widely between wards. The City has low rates of child poverty except for some pockets, such as Portsoken Ward in the east of the City.

Hackney has high mortality rates from preventable diseases. The factors behind these include smoking, obesity, poor diet, inactivity and high levels of deprivation. Deaths from cardiovascular disease are higher than elsewhere in the country. Hackney has more smokers than in most parts of London. Many adults and children are obese - including more than 40% of school pupils in Year 6. Our residents are more likely to be living with a long-term condition, such as diabetes, lung conditions, heart problems or diabetes and more likely to find it difficult to manage these. We also have a high number of local people with mental health conditions including severe and or enduring mental illness.

With our growing local population there will continue to be increasing demand for healthcare and we rely on an ageing estate in the health and care sector and a number of challenges around the recruitment and retention of staff. We also know that we cannot address the health needs of a population by looking at health and care provision alone. The Marmot Review emphasised just how much health is influenced by the wider determinants of health, and the community strategies of both the London Borough of Hackney and the City of London Corporation reflect this. The approach of the City and Hackney system, since its successful inclusion as a devolution pilot site in 2015, has been to focus on shared solutions, an integrated whole-system approach, and supporting local communities to meet their own needs.



A City and Hackney life course

BIRTH
There are 4,500 babies born each year to mothers from Hackney and the City

76%
Babies vaccinated at 12 months

EARLY YEARS
There are 21,000 (7%) 0-4 year olds living in Hackney, and 300 (4%) living in the City

25%
Children in low-income families (Hackney)

SCHOOL AGE
There are 43,000 (15%) 5 -17 year olds living in Hackney and 700 (9%) in the City

42%
Year 6 children overweight or obese

WORKING AGE
There are 197,000 (70%) 18-64 year olds living in Hackney, and 5,400 (70%) in the City.

21%
Adult smokers (Hackney)

22%
Adults binge drinking

OLDER PEOPLE
There are 20,800 (7%) over 65s living in Hackney, and 1,300 (17%) in the City. This proportion of the population is expected to grow.

554
Hospital admissions due to falls (65+)

66%
Uptake of flu vaccination (65+)

END OF LIFE
Each year around 1,100 Hackney residents die, and 30 City residents.

82.8
Female life expectancy (Hackney)

78.9
Male life expectancy (Hackney)

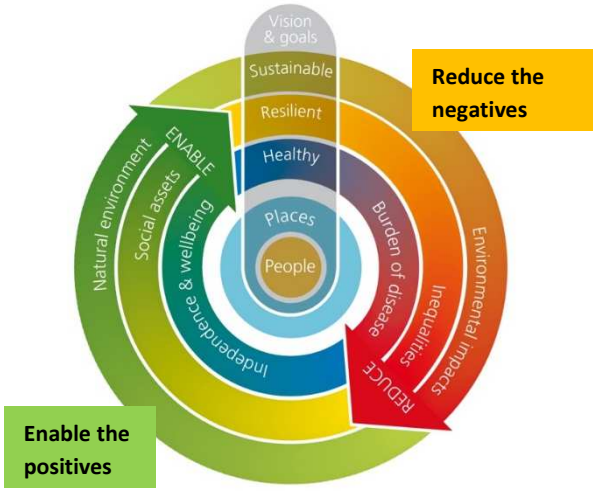
N.B. Red, amber or green circles reflect how City & Hackney figures compare with national averages

Our Integrated Commissioning and Care Programme: a local partnership to address the health and wellbeing needs of local people

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 through our Integrated Commissioning and Care Programme. The programme is designed to deliver better healthcare for patients in a system which functions more efficiently through:

- **Sharing learning and resources between organisations:** the programme unites organisations who have historically delivered or commissioned similar services for patients and considers the best way we can collectively use our system resources, including data, buildings and staff, and manage and reduce risk together, in order to provide the highest quality care possible for patients,
- **Joining up financial resource:** we understand that by joining up our financial resource we can make best use of the City and Hackney pound,
- **Changing how we deliver our services:** our services can be more efficient and effective if we make them more personal, local and if we constantly seek to improve their quality. By taking joint accountability for change, we make this happen.

Our **care workstreams** are how we have arranged our services; each of our workstreams are responsible for delivering a programme of work across a specific portfolio area. Our four workstream areas include **Unplanned Care, Planned Care, Children Young People Maternity and Families** and **Prevention**. Each care workstream is managed by a Board or Leadership Group.



Our vision

Working together across City and Hackney to support people and their families to live the healthiest lives possible and receive the right care when they need it.

- **More support** for patients and their families to get healthy, stay well and be as independent as possible
- **Neighbourhoods** where people and communities are actively supported to help themselves and each other
- **Joined up support** that meets the physical, mental and other needs of patients and their families
- **High quality** GP practices, pharmacies and community services that offer patients more support closer to home
- **Thriving local hospitals** for patients when they need them

Our strategic objectives

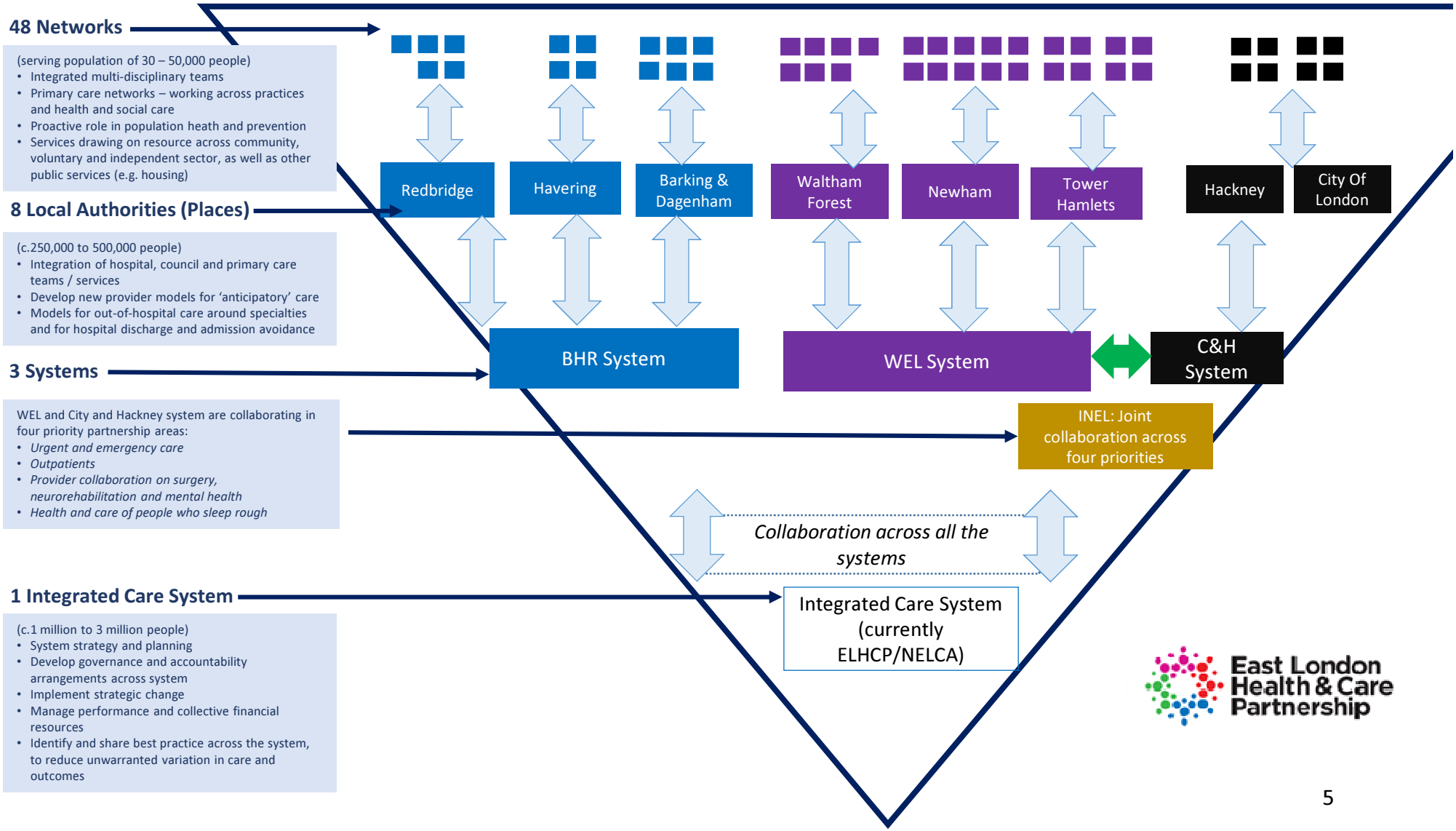
We have developed five strategic objectives for the programme:

- **Deliver a shift in resource and focus on 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**

The following organisations are involved in the programme:

- The London Borough of Hackney
- Corporation of the City of London
- City and Hackney NHS Clinical Commissioning Group
- East London NHS Foundation Trust
- City and Hackney GP Confederation
- Homerton University Hospital NHS Foundation Trust
- City and Hackney Local Pharmaceutical Committee
- Schools and Children's Centres
- Hackney Centre for the Voluntary Sector
- A range of local voluntary and community organisations
- Healthwatch City of London
- Healthwatch Hackney

The wider context: City and Hackney as part of the integrated, collaborative health and care system in North East London



Improving the context within which services are delivered

Our Outcomes Framework

To ensure that everyone understands how the strategic objectives of the programme are aligned to outcomes that matter to residents and patients, we have co-produced an outcomes framework which is co-owned by residents and system partners.

Priority area		Programme-level outcomes
1	Making sure all children and young people (CYP) have a good start in life	• CYP are supported to aspire and achieve optimal levels of development for their age • CYP feel and are safe in their local environment and home • CYP's physical and mental health is optimised in order to support / enable them to realise their potential • children and families experience safe and positive births and are supported to optimise health, wellbeing and development during the first 1,000 days
2	Achieving a reduction in the present inequity in health and wellbeing (as well as contributing towards reducing inequity in other areas outside the remit of the Integrated Commissioning Programme). This includes closing the health and wellbeing gap for people with long term conditions and co-morbidities.	Inequalities in healthy life expectancy are reduced Rates of infant mortality, stillbirths, neonatal and maternal deaths are reduced Patients feel supported to manage their own conditions and care for as long as possible The wellbeing of people with long-term conditions is improved
3	Increasing the length of a healthy life, so that local people have both longer lives and more years spent free of ill-health and disability.	Quality of life for people in City & Hackney is improved
4	Tackling the causes of poor health and wellbeing at an earlier stage and putting in place measures to ensure better prevention.	Smoking prevalence is reduced Obesity is reduced for children and adults Increased breastfeeding prevalence Perinatal mental health is improved Reduced prevalence of causes of ill health Prevalence of problematic alcohol use is reduced
5	Creating 'services that work for me', or services that are more joined up and person centred.	The local health and care workforce are empowered to have conversations with patients and the public about their health and wellbeing
6	Improving the mental health and wellbeing of the local population, including ensuring better access to mental health care.	People with mental health conditions are better able to manage their conditions Improved mental health and wellbeing among children and young people
7	Helping local people to become resilient and empowered, increasing people's sense of control, autonomy and self-efficacy. This includes encouraging people to become involved in their own care and to understand and manage their own health better.	People feel more empowered to manage their own health better Workforce have the skills and knowledge to support people in navigating the health and care system
8	Reducing social isolation	Still to be decided
9	Increasing employment	
10	Creating a safe environment for everyone to live in, for example by linking in with housing services.	

Our major programmes of work

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.

Hosted by the Unplanned Care Workstream, City and Hackney's **Neighbourhoods Programme** is redesigning how care is delivered to patients at a primary and community care level. The Neighbourhoods Programme has developed 8 Neighbourhoods across the two local authorities, supported by multi-disciplinary teams who will use population-data to tailor care to the needs of local people, deliver care closer to patients' homes, and 'wrap around' the individual to improve the patient's experiences and outcomes. Each neighbourhood is working to develop broader links with other services that impact on the health of residents, such as housing, leisure and green spaces and employment support. The Neighbourhood footprints are well established and we are rolling out different services and models of care through 2019/20. Neighbourhoods are coterminous with Primary Care Networks.

The **Outpatients Transformation Programme,** hosted by the Planned Care workstream, brings together system partners to modernise and improve outpatient care on a pathway basis involving a specialty by specialty review. The programme seeks to improve advice and guidance to GPs and patients, promote self-care and self-management, and to avoid unnecessary follow-up activity, looking for ways of providing appointments in a variety of non-face-to-face methods (virtual, telephone, video) or transferring work to the community/primary care where appropriate. It will closely integrate with both the Prevention workstream and the Neighbourhood Health and Care Services programme.

The **Neighbourhoods Health and Care Services Programme,** hosted by the Planned Care Workstream, has set out to transform City and Hackney out-of-hospital community services, including social care, mental health, whole-population primary care, and services based in the community. The programme has brought together providers to develop a delivery model, and after initially running in close partnership with the Neighbourhoods Programme, these programmes are now merging.

We are in the process of developing **Primary Care Networks (PCNs);** groups of between 3 and 7 GP Practices working to deliver improved outcomes for local patient populations. Each PCN will have a Clinical Director who will lead service transformation and quality improvement, and will provide a link back to the IC programme. By 2024 PCNs across City and Hackney will be staffed with pharmacists, social prescribers, first contact physiotherapists and physician associates.

The **Making Every Contact Count (MECC) Programme** is being hosted by the Prevention workstream. MECC will support and empower City and Hackney health and care staff to maximise every contact they have with patients and the public to promote positive wellbeing and signpost them to local preventative services and other sources of support. Over the coming years, training will be rolled out to staff across the system to develop their skill sets and build capacity. The programme is being co-designed with residents and staff.

Transforming out-of-hospital care and fully integrating community care

Our Neighbourhoods Programme began in April 2018 and is in the process of re-designing primary and community care in order to deliver locally integrated health and care services that are responsive to local residents, and support them to stay well. The programme is focused on **meeting the health and wellbeing needs of local communities** whilst **addressing the wider social and economic determinants of health for the whole population**. Early intervention and prevention are prioritised and the programme operates across the local system with the inclusion of commissioners, providers of health and social care services and a wide range of community and voluntary sector partners. The programme has been designed through engagement and co-production with local people.

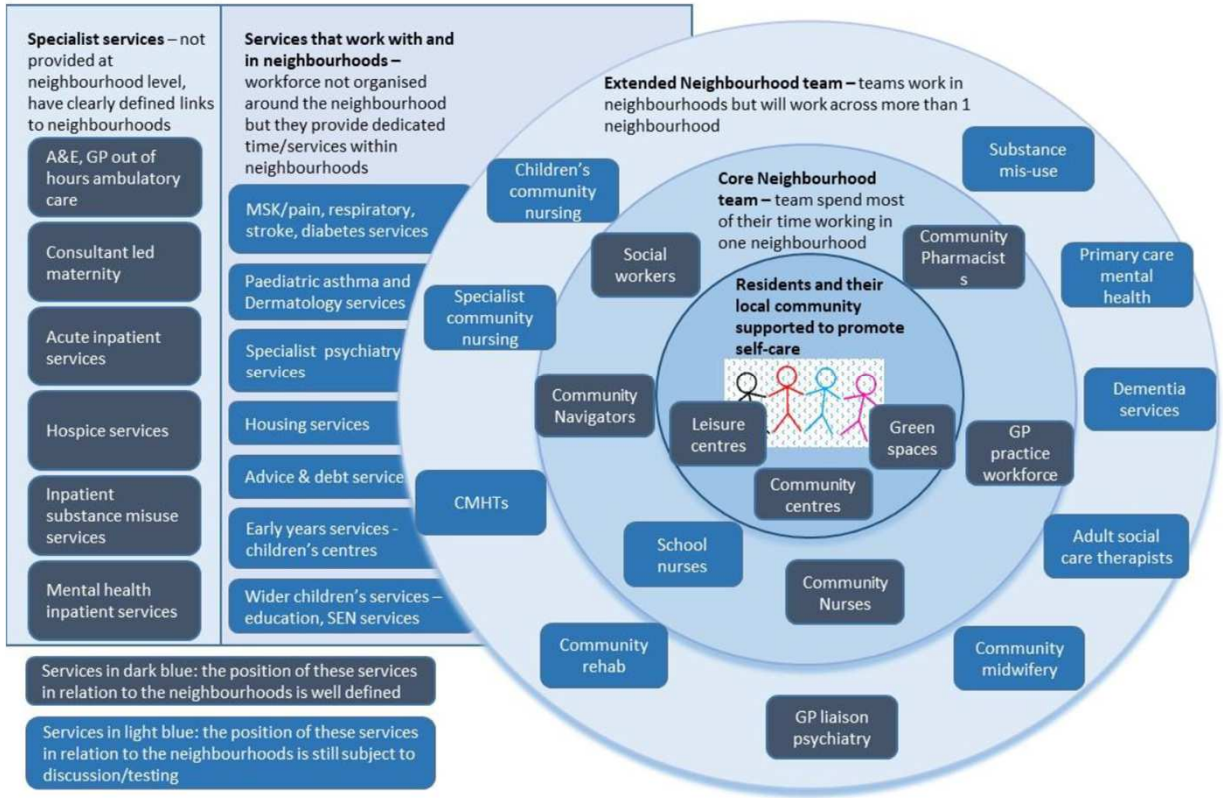
Through the Neighbourhood Health and Care Services Programme we aim to **transform and integrate the provision of out-of-hospital services**, informed by whole system workshops held in January 2019.

We want 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 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 and be delivered closer to people at the neighbourhood/network level.

From our **engagement with residents, patients and service users** so far, the following themes have emerged:

- People want us to 'bring services back' to City and Hackney (e.g. placements for children in care, elderly residents based out of the local authority)

Proposed model of how services and teams could be organised around neighbourhoods



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.

The new GP contract nationally specifies seven key services for **Primary Care Networks**. Most of these nationally mandated services map onto existing project or pilots within our integrated commissioning programme, for example anticipatory care will build upon the 'residents with complex and diverse needs' project within the Neighbourhoods Programme as well as care navigation work within the Prevention Care Workstream.

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. We have developed a wide range of appropriate care pathways with a rapid response element to keep people out of hospital, including step up care within the reablement team (IIT) the Paradoc service (described below), and Duty Doctor (where a practice-based doctor is always available to see or speak to patients urgently to avoid hospital). Over the next 10 years we will further strengthen this system and look at ways in which we can reduce duplication and improve quality of care. We will also talk to our residents about their health-seeking behaviours and design a system which makes sense to them without unnecessary burden on the hospital. This would not be possible without the strong partnerships links we have already.

End of Life care: The City and Hackney system is already high-performing in this area, with very good primary care for End of Life and high uptake and use of care plans through Co-ordinate My Care (by all partners as well as primary care). This has been achieved through the End of Life Care Programme Board and an extensive programme of training. Previous reviews having identified a specific issue around homeless people and their experience of end of life care and this is a priority area for us. We are considering the Pathways model for homeless people, and this is an area where we are contributing to a multi-local authority approach through the INEL System Transformation Board. We are also introducing an urgent end of life care service (based on a hospice at home model) that will support people that want to die at home.

Dementia: Our new City & Hackney dementia service has significantly more capacity to support people with dementia and their carers. Depending on the complexity of their case and needs, every patient now gets an allocated navigator or specialist nurse to support them as well as resource packs for family and friends and access to a digital carer's support tool. All system partners are using Co-ordinate My Care to provide a shared care plan. We are looking to integrate the dementia team into each neighbourhood to provide better wrap around care for people in the community.

Preventing falls: Taking a whole-systems approach we have worked collaboratively with partners including LAS and Paradoc. Paradoc is a locally commissioned team made up of a GP and a paramedic who work as an alternative to LAS and respond to a large number of falls and focus on working in the patient's home when a fall occurs rather than bringing them to A&E. We have launched a primary care falls pathway – and are including systematising this in EMIS. We are in the process of reviewing our exercise services and we are looking to develop tools to better identify people at risk of falling. Work is also taking place to reduce falls in hospital.

From our **engagement with residents, patients and service users** so far, the following themes have emerged:

- People want well-co-ordinated and safe out of hours services
- Across the board attendees are expressing a need for 'bridging or transitioning' 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
- Support is wanted to help people overcome barriers around finance and transport

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.

From our **engagement with residents, patients and service users:**

- There is a willingness to embrace new technologies, but not at the expense of face-to-face appointments with their GP. People on one hand want health services to be able to share information to help wrap care around the patient, but on the other are worried about data protection issues.

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 colleagues in the London Borough of Hackney to integrate the Three Conversations model in 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. For example:

- Our social prescribing service which operates in every GP practice in City and Hackney and is working with PCNs to integrate new provision;
- Peer support and group consultation pilots have been started or completed and we are exploring options to mainstream findings
- The Neighbourhoods community navigation model is being developed with PCNs, the Provider Alliance and local stakeholders

Our local integrated urgent care system aims to provide patients with more options and advice at the right time, for example non-clinical navigators in A&E work with residents to signpost them to other services if A&E is not appropriate for their care

Personal health budgets (PHBs) are a lever for giving people more control of their health and as well as the mental health recovery pilot mentioned below, we have plans in place to more systematically link personal health budgets with social prescribing and to extend PHBs to new areas, starting with the CAMHS service.

Personalised care in mental health

We are piloting the use of mental health personal health budgets as part of the secondary care discharge pathway. Currently patients can access IAPT services online including online therapies. We are also piloting the use of digital therapies beyond IAPT services. At present dementia patients can access online care plans and we plan to expand online Recovery Care Plans and online referrals and booking to other service areas.

From our **engagement with residents, patients and service users** so far, the following themes have emerged:

- Access to community based, non-clinical services with a more holistic approach is important
- Young people want more tailored health and wellbeing services that acknowledge the pressures and concerns in their life such as social media, the pressure to look in a certain way, mental health, crime and violence and relationships & sex

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.

As mentioned above, the Neighbourhoods Programme and the Community Services Development Board are working with social care and PCN partners to propose a combined approach to integrated care in out of hospital services to the Integrated Commissioning Board in September 2019.

Our aim as part of this programme is to update the original Neighbourhoods blueprint to reflect developments around PCNs and out-of-hospital care services, resulting in a the first phase of a Target Operating Model being agreed in January 2019 and implementation of an integration programme beginning in April 2020.

Enabling our strategic programmes

The local system includes enabler groups which support the work of the integrated care workstreams. These groups establish strategies and roadmaps for delivery and prioritise investment of delegated funding towards specific enabling projects in the areas of IT, workforce, primary care and estates. They manage risk around delivery of these projects, and work to address gaps or new priority areas as they arise.

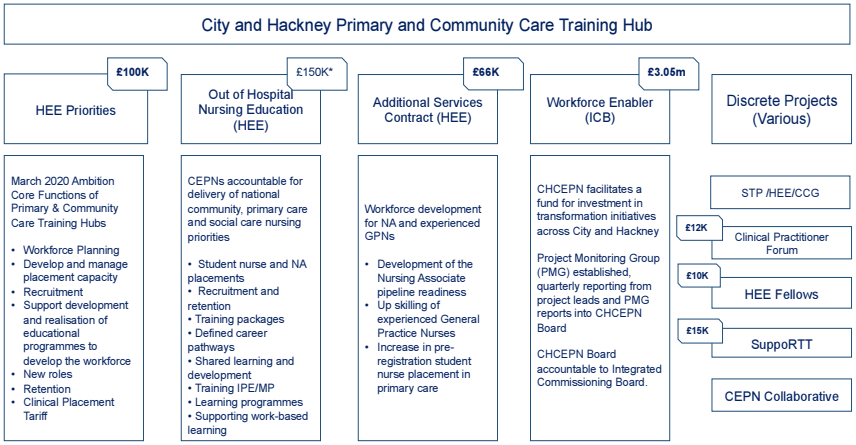
Estates

City and Hackney has an ageing primary and community health estate. Since 2015, when City and Hackney was successful as a devolution pilot site, health and local authority partners have recognised the significant opportunities to enable greater social and community value for residents from the current estate through greater integration and joined-up planning across health, social care and community partners.

Our estates strategy is focused on improving the productivity and efficiency of estates usage, transforming the estate so that it supports our Neighbourhood model of service delivery, and working with partners to find flexible ways to prioritise and fund infrastructure changes. This joint approach is leading to targeted regeneration work aiming to address pockets of significant deprivation.

Workforce

The Long Term Plan describes how workforce growth has lagged behind need, partly due to increasing demands on the NHS and also due to inflexible employment practices. Our Community Education Provider Network (CEPN) now operates as the local system Training Hub, with a remit to support key local, regional and national workforce transformation programmes:



Communications and Engagement

The Comms and Engagement Group recognises the importance of patient and public involvement, engagement and co-production in the development of new service models. The Group will support our aims for a Co-Production Council to be a central part of any new local health and wellbeing partnership.

Primary Care

The City and Hackney system is proud of the achievements delivered by its local GP practices. Through investment in whole population contracts, our GP workforce has topped national comparative tables on quality and achieved some of the lowest referral rates into secondary care, making use of clinically appropriate alternative pathways outside of hospital.

Like the rest of North East London, City and Hackney faces an increasing population whilst having a reducing GP workforce and rising demand for GP appointments. However, unlike the rest of our wider system, City and Hackney has better GP coverage (6.5 GPs per 10K population compared to 4.5 in Redbridge, for example).

As part of work across NEL we will ensure the following quality aspirations are delivered by 2021:

- We will aim to achieve a CQC rating of good or outstanding for 95% of practices
- We will aim to have at least one QI expert per network
- We will ensure workflow optimisation in each practice across NEL
- We will develop a NEL wide QI methodology to ensure a consistent approach and shared learning across the STP
- We will aim to implement best practice key principles for at least 5 care pathways across NEL within the available local resources to deliver consistent access and quality of services

Digital

The Digital Enabler Group oversees a number of vital projects across the key workstream priorities, governed by a set of digital objectives (below). Whilst only one part of its work, electronic patient records are a foundational element. Full interoperability (not just shared access) in relation to electronic patient records and care plans is fundamental to our vision of integrated care and we are working with STP partners to continue to develop and expand the functionality of HIE (Health Information Exchange) as well as increasing the number of systems within it.

The Digital Enabler Group has the following digital objectives across the local system:

- Information sharing between partners to enable integrated care
- 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
- Embedding the prevention agenda across our system
- Closer working with a wider range of non-statutory partners
- Digital solutions to save clinical and administrative time
- Digital solutions to support patient access to services

Examples of innovation in our local approach

Our full local strategic plan includes a detailed breakdown of the many targets and ambitions set out in the NHS Long Term Plan, and sets out our local system response and how our plans will be delivered.

We have set out here some examples of the local priority work which demonstrates the spirit of innovation and high quality in the City and Hackney system:

Health and wellbeing services for rough sleepers

The City of London has one of the highest numbers of rough sleepers in the country. As a result, services for rough sleepers are a particular priority locally where Public Health commission a multiple needs service, and we are sharing learning across the multi-local authority area. The London Borough of Hackney also has a homeless strategy (piloting a 'Housing First' approach with system partners for patients with complex health needs) and we have successfully been awarded funding as part of the new models of care proposals for community mental health via ELFT to specifically address the mental health needs of rough sleepers (see below).

Previous reviews have identified a specific issue around homeless people and their experience of end of life care and this is a priority area for us and we are considering the Pathway model for homeless people.

Neighbourhoods Mental Health Transformation

Through ELFT, City and Hackney, Newham and Tower Hamlets have been successful in securing transformation funding to develop local neighbourhood / primary care network based mental health models.

City and Hackney has comparatively well-developed primary care mental health services which integrate secondary care, primary care and VCME providers through an alliance contract. The services are focused on patients with severe and enduring mental health problems and include Mental Health Enhanced Primary Care (EPC), Primary Care Liaison (PCL) and SMI physical health checks. City and Hackney came top in national performance comparisons for its coverage of SMI physical health checks and its multi-agency model.

The new funding will enable this foundation to be built on and for services to be fully aligned with the vision for SMI in the Long Term plan. EPC will be expanded to provide a mental health team in each neighbourhood, which is capable of offering assessment, step down, step up and on-going support, recovery care planning, therapy and wellbeing services. Furthermore, the EPC team will be blended with community connectors from VCSMEs. The main focus will continue to be severe and enduring mental health problems including SMI, Personality Disorder and trauma. The Transformation Funding will reduce the number of people needing to be seen in secondary care and will create place-based services, personalised around people's needs and embedded in the communities people are part of.

Prevention Investment Standard

Investing in prevention is a system priority for City and Hackney as exemplified by the Integrated Commissioning Board strategic objectives (both to "deliver a shift in resources and focus to prevention" and to "ensure we maintain financial balance"), and the NHS Long Term Plan.

The City and Hackney system is making a commitment to grow investment in prevention activities year on year at a faster rate than growth in general health budgets. This Prevention Investment Standard (PINS) will support a shift in investment and focus towards health as an asset to be protected through prevention activities. Alongside the PINS we will create a Prevention Investment Fund (PIF) which will be the funding vehicle to pilot prevention activities non-recurrently.

The Prevention Investment Standard will allow the City and Hackney system to:

- understand its level of investment on prevention activities;
- ensure, as a minimum, the level of investment is protected;
- ideally increase the allocation of funding towards prevention activity while delivering current priorities and required outcomes;
- change the culture of local organisations to prioritise prevention and promote understanding of the role that all local partners can play in delivering prevention initiatives;
- increase the capacity and capability of system partners to deliver prevention activities; and
- monitor and deliver a financial return on investment in prevention, improving system financial sustainability.

Better services for people to help them age well

City and Hackney's urgent care system makes effective use of rapid response services to prevent avoidable emergency admissions and treat patients closer to home. We are establishing better care in people's homes, particular for conditions such as dementia.

We have a very small number of local care homes (only four) and the home care market faces some workforce pressures, which we are expecting to increase as a result of Brexit. In the longer term, as part of our commitment to providing community-based care, we are scoping for more nursing home provision in both local authority areas.