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 socia l 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 person 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		