ANNEX B

DRAFT 2020 - 21 CITY AND HACKNEY SYSTEM INTENTIONS

Summary version

Version 3 – 20/09/19

NHS
City and Hackney
Clinical Commissioning Group

NHS
East London
NHS Foundation Trust

DOMINE DIRIGE NOS
CITY OF LONDON

City & Hackney
GP Confederation
A community interest company

NHS
Homerton
University Hospital
NHS Foundation Trust

Hackney

PLANNED CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :

- Community services transformation in Neighbourhood Health and Care for people with long term conditions.
- Transformation of Outpatient services at Homerton.
- Support the mental health and well being strategy; improve opportunities for access to housing for vulnerable and disadvantaged groups; drive an integrated strategy for people with learning disabilities with a strong focus on prevention and reducing inequalities.

Outpatient Transformation

- Virtual clinics for first appointments and follow ups
- Pathway development
- Digital innovation
- Self management support

Personalised care and coproduction

- Ensure coproduction is in place throughout the workstream activities involving residents service users, carers and staff at all levels
- Development of the cross cutting cultural change to support personalised care in our services
- Development of infrastructure to support choice and control across health and social care
- Increase uptake of Personal health budgets (PHBS) and direct payments
- Development of a specific PHB offer to people with learning disability to support new strategy

Neighbourhood health and care services

Supporting the development of the provider alliance to deliver integrated community services at the neighbourhood/network Including:

- Community gynaecology and women's health service
- Community ENT
- Respiratory – integrated community consultant offer increased capacity for pulmonary rehab, early identification, medication support and peer support
- Renal – community consultant input
- Community dialysis
- Community diabetes
- Heart failure service for IV diuretic
- Stroke – recovery and rehabilitation support

- Support the ACN service and the core neighbourhood team in delivery of CHC
- Development of specialist skills and increased capacity – e.g. MH and neuro pathways

Mental Health

- Mental Health neighbourhood transformation programme
- The Provider Alliance
- MDT model for physical and mental health interface

Housing and Accommodation services

- Implement Housing Frist
- Redesign of high needs residential services with ELFT
- Strengthen CHC offer for adult mental health
- Review the role of the ELFT rehabilitation team and if the model could be expanded to support people with Learning Disability returning to local services

---

Children and Young People (with the CYP Workstream)

- Strengthen our approach to Care and Treatment Reviews and interventions for children and young people with a learning disability or autism – supported by our Darzi fellow

Prescribing

Medicine Optimisation

- Improving transfer of about medicines at hospital discharge
- Pathway updates for anticoagulation

Primary care and primary care networks

- Peer review and audit of referrals by practices
- Network involvement in development of and delivery by the Provider alliance
- Education and support to maintain early diagnosis of cancer and provision of services for cancer survivors for follow up care, screening access and awareness
- Physical health checks and action plans for people with a learning disability

Continuing Healthcare (CHC)

- Continued improvement of local delivery
- Partnership strategic planning for local nursing home provision and funding arrangements
- Implementation of NEL review

Services for people with Learning Disabilities

- ILDS service transformation
- C&H strategy for people with learning disabilities
- Transforming Care Programme (TCP) and Long term plan
- Physical health
- Cost and implement the strategy with a focus on prevention
- Increasing access to mainstream services and asking partners to ensure reasonable adjustments for people with learning disability and autism
- Strengthen our preventative approach in our TCP

Long term conditions (with prevention Workstream)

- Secondary prevention and services supporting people in the community
- Cancer – Early Diagnosis, Faster Diagnosis standard, screening awareness and supporting people in recovery

North East London- System Transformation Priorities:

- Integrated care system development; Outpatients transformation; Surgical redesign

UNPLANNED CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :
Bring together partners to create services that meet people's urgent needs and support them to stay well

Integrated Urgent Care

- Implementation of effective out of hours primary care services - 111, extended access hubs, GP OOH
- Implementation of streaming and redirection model at the front door of A&E
- Maximise use of appropriate care pathways (Paradoc, IIT, MH crisis line) working with LAS and primary care
- Improvements and enhancements to falls pathway
- Implement actions from the Duty doctor review
- Review of ambulatory care services
- Engage with the public to increase awareness of urgent care services
- Ongoing roll out and realise benefits from CMC care plans - including introduction of My CMC
- Working with public health to support procurement and implementation of a new substance mis-use service
- Progress blended payment - the new tariff for emergency hospital care

Neighbourhood

Supporting the development of the provider alliance to deliver integrated community services at the neighbourhood/network Including:

- Development of the anticipatory care service as part of the neighbourhood model, including the development of a core integrated team around each neighbourhood and an effective model of navigation
- Transformation of adult community nursing and adult community therapies

Establishment of a model for how the neighbourhood structure provides a framework for effective involvement from the voluntary and wider community sector

Work with partners to maximise the potential that neighbourhood working brings to address the wider determinants

Improve Patient flow and Discharge Pathway

- Delivery of DToC case notes audit action plan.
- Review and implement a sustainable discharge to assess (or other) model.
- Improved primary care and wider system support to our local care home residents
- Review of Intermediate care services and interim care bed provision
- Better pathways for homeless people coming out of hospital.
- Improved support to local care homes, and improved working between care homes and hospitals - including introduction of trusted assessor and red bag scheme

Mental Health

- Development of High Intensity Service User service for frequent users of A&E, 111, LAS based on the results of the pilot
- The expansion of alternatives to crisis
- Embedding the community dementia service within the neighbourhood model and greater integration with adult social care

End of life care

- Implementation of new Urgent end of life care service
- Better support at end of life for homeless people, working with local hostels

Strategic Priorities

- Develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- Provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information
- Develop urgent care services that provide holistic, consistent, care and support people until they are settled
- Work together to prevent avoidable emergency attendances and admissions to hospital
- Provide timely access to urgent care services when needed, including at discharge
- Deliver models of care that support sustainability for the City and Hackney health and care system.

CHILDREN, YOUNG PEOPLE, MATERNITY AND FAMILIES CARE WORKSTREAM: 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective :

Continue to work to give our children and families the 'Best start in life' (LTP 2019) including commissioning high quality services, that maximise health and wellbeing outcomes for families throughout the early part of the life course

Children and Young People

- Continue to develop and embed partnership arrangements to deliver Transforming Care and preventing the avoidable admission of CYP with autism and / or LD who display challenging behaviour to specialist inpatient hospitals
- Development of an integrated commissioning framework and service model for CYP SaLT provision
- Continue the development of monitoring and review processes to support the delivery of SEND requirements
- Mobilise the reconfigured child health clinics across agreed general practices.
- Initiate joint reviews for Occupational Therapy, and explore reviewing the commissioning of Learning Disability across the partnership
- Commission a sickle cell mentoring scheme across the STP
- Recommission the Early Years' service recognising the reduction in available funding, and work to develop the coding of CYP with complex needs and including autism, ASD, and LD.
- Continue to commission our strong Health Visiting, School Based health (school nursing) and Family Nurse Partnership services.
- Redesign the CYP physical activity services
- Commission the redesigned Young Hackney Substance Misuse Service over the next year.

Maternity

- Continue to focus on quality improvements in service delivery,
- Accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025
- Build on our strong trajectory in continuity of carer implementation
- Support women to access OTC and prescription medicines throughout the antenatal and post-natal periods
- Improve women's experiences of maternity care
- Collaborate with the Prevention workstream to focus on implementing the new smoking in pregnancy pathway, and support the development of the MECC programme

Integrated Service model

- Implement an integrated service model for the health assessment, caseload management and nursing provision for looked after children placed by / in City and Hackney, and a comprehensive health offer for care leavers up to the age of 25.
- Create a single point of access and a work toward a fully integrated Tier 3 CAMHS service (including CAMHS disability services)

Improve immunisation coverage

- Continue to work with the GPC and system partners to improve childhood immunisation coverage and childhood flu, utilizing the developing neighbourhood and Primary Care network structures
- Promote the offer of the flu vaccination and pertussis for expectant mothers

Child and Adolescent Mental Health

- Development of 24/7 Crisis pathway for CYP and agreeing models for delivery
- Development of a comprehensive 18-25 Transitions service (Tier 2 and Tier 3) in line with national requirements
- Development of an improved offer for the mental health of very young children (0-5) and their parents which incorporates work from the ACEs project team.
- Continue to roll out our Wellbeing and Mental health in schools work (WAMHS) to all state maintained schools and develop a similar offer to state registered Independent schools that have a majority City and Hackney population

Digital innovation

- Maximise our digital capability through implementation of an integrated patient journey management system across CAMHS services.

Working with our VCS partners

- Continue to review the opportunity to integrate our VCS KIDS and Huddleston short breaks services with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme
- Continue to commission our VCS providers to deliver antenatal support for our most vulnerable women
- Continue to review the opportunity to integrate our VCS KIDS and Huddleston short breaks services with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme.
- Deliver work to improve the mental health of Black African and Caribbean heritage young people at key transition points. We will be supporting our partners to deliver this from late 2019.
- Continue to commission the delivery of our VCS pilot 18-25 year old transition service

PREVENTION WORKSTREAM : 2020 - 21 SYSTEM INTENTIONS OVERVIEW ON A PAGE

Over-arching Care Workstream objective:

- Reduce the harms from the main preventable causes of poor health.
- Take early action to avoid or delay future poor health.
- Support and enable people to take control of their own physical and mental wellbeing.
-

Long term conditions - earlier intervention

- Start work to refocus the Long Term Conditions (LTC) contract with the GP Confederation to have a stronger emphasis on incentivising prevention.
- Areas identified with potential to include/enhance incentives for: alcohol screening and brief advice; reducing variation in referral rates to stop smoking services; COPD and asthma prevalence/case finding; group consultations and self-management; identifying and improving access to support for carers (including linking in to new carer support services in Hackney and the City); implementing annual reviews for other conditions (epilepsy, sickle cell); amongst other things.
- Another opportunity identified is the integration of the NHS Health Check contract within the LTC contract to optimise and align incentives for cardiovascular disease (CVD) prevention in primary care.

Rough Sleepers

- Use the learning from various local pilots currently underway/planned to inform the development of effective care pathways for rough sleepers in Hackney and the City.

Supporting people to take control of their own health and wellbeing

- Re-commission the existing Social Prescribing service to integrate fully with new funded Primary Care Network provision and align with the new Neighbourhood community navigation model.
- Improve access to, and awareness of, local prevention services using the learning from two digital pilot projects (Digital Social Prescribing Platform and Directory of Services).
- Use the learning from the 'three conversations' innovation site to embed a strengths-based, preventative approach across social care practice in Hackney.

Sexual Health

- Work with the Planned Care Workstream to develop a collaborative approach to commissioning women's sexual and reproductive health services.

Learning disability and prevention

Collaborative working with Planned Care colleagues to implement actions on prevention as set out in the new City and Hackney Learning Disability Strategy with focus on

- Increasing access to mainstream services and asking partners to ensure reasonable adjustments for people with learning disability and autism

Obesity

Collaborative working to tackle obesity locally will continue through a new 10 year strategic 'healthy weight' framework, which has been co-produced with a broad alliance of partners.

Planned Care Workstream

- Commission a new weight management service to meet the needs of people with complex needs who are not eligible/suitable for bariatric surgery.

CYPMF Care Workstream

- Undertake a review of the child obesity pathway, with a focus on complex needs provision.

Alcohol, Substance Misuse and Tobacco Dependency

- Embed tobacco &alcohol screening and brief advice targets as service KPIs from 2020/21.
- Complete the re-procurement of a new integrated City and Hackney adult substance misuse service.
- Collaborate with North East London partners, working in partnership with Homerton and ELFT, to develop a business case to implement the Ottawa inpatient model of bedside support to quit smoking.

Mental Health

- Design a new service offer to better support a targeted preventative approach to improving mental wellbeing, informed by the new City and Hackney Mental Health Strategy and the findings of an evaluation of the Wellbeing Network
- Continue to work with local VCSE and statutory providers to improve the offer of supported employment provision for people with mental illness, learning disabilities and other support needs

Making every contact count (MECC)

- Embed MECC principles in health and care service provision through appropriate contractual levers, to support the sustainability of our approach to system-wide action on prevention.