DRAFT 2020 - 2021 City and Hackney System Intentions

Version 3 – 20/09/19

NHS City and Hackney Clinical Commissioning Group

NHS East London NHS Foundation Trust

City of London

City & Hackney GP Confederation
A community interest company

NHS Homerton University Hospital NHS Foundation Trust

Hackney

1. Introduction & Background

Scope

The move towards an Integrated Care System by 1 April 2021 sets a requirement within City & Hackney to migrate from "commissioning intentions" to "system intentions". This means working in partnership with our Providers to put in place integrated health and social care services which meet the needs of our changing population. Within City & Hackney, wherever possible we work in partnership with our Providers and have a co-production mind-set. Within this document City & Hackney's System Intentions are structure in line with the four care workstreams which deliver services within the local system, specifically: Unplanned Care, Planned Care, Prevention, Children, Young People, and Maternity & Families. Our major Providers and Partners within City & Hackney are:

City & Hackney's main Providers & Partners	
• Homerton University Foundation Trust	• London Borough of Hackney
• East London Foundation Trust	• City of London Corporation
• Barts Foundation Trust	• 3rd Sector Organisation / Community Providers
• North East London Foundation Trust	• London Ambulance Service
• University College Hospital Foundation Trust	• Private Sector Providers
• GP Confederation	• Healthwatch Hackney
• Healthwatch City of London	• Voluntary and Community Sector (VCS) / Hackney VCS

In drafting City & Hackney's 2020/21 system intentions, it is clear that the change to "system intentions" will be incremental. The roadmap for our system intentions mean that we will need to:

- Manage existing contracts to their contractual completion before we can transform them.
- Ensure that we have rigorous assurance processes in place to check that when new services are commissioned that we think innovatively regarding the range of Providers who can deliver health and social care services and how they might be delivered.
- Collaborate with existing and new Providers to co-design/co-produce new health and social care services which deliver on the goals set out in the NEL STP response to the Long Term Plan.

New contracts will have a particular, but not exclusive, focus on:

- Supporting the development of Primary Care Networks, neighbourhood and community services in order to transform these services for patients and the public.
- Taking an innovative approach to how we address long term conditions
- Supporting a step-change in our approach to prevention services for City & Hackney residents
- Creating seamless urgent care services which will complement our acute and primary care services

Our Mental Health System Intentions are integrated within each of the four care workstreams. In addition, we have drawn attention to our five Mental Health priorities and the associated services namely; prevention, access, neighbourhoods, personalisation and co-production and recovery.

Our process for developing and signing off our 2020/21 System Intentions

Our System Intentions were developed by:

- Inviting Care Workstream Directors to document the system intentions for their workstreams through discussion and engagement with Providers, Partners and Stakeholders within their respective workstreams;
- Ensuring that all four Care Workstream Boards sign-off on their individual 2020/21 System Intentions;
- Securing signoff to the integrated City & Hackney System Intentions from the City & Hackney Accountable Officers Group; and subsequently
- Securing signoff to the integrated City & Hackney Systems Intentions from the City & Hackney Integrated Commissioning Boards (which meet in common).

The remainder of this document sets out the narrative for City & Hackney's System Intentions.

Further details on our areas of work which will underpin our transformational services in 2019/2020 and 2020/21 can be found in the following annexed documents:

A. 2020 - 21 City and Hackney System Intentions partner specific changes
B. Draft City and Hackney 2020 - 21 System Intentions: Overview on a page

Planning for Contractual Change required by System Intentions

Many of the aims and objectives proposed in these System Intentions will require contractual interventions in order to be delivered. These will take the form of contract developments for the 20/21 contracts or Contract Variation in the 20/21 contract year. Examples of contractual interventions that may be required are specifying new or additional service developments, changes to the funding of existing or modified services, changes to existing service specifications, and decommissioning of all or part of existing services.

It is important therefore in the spirit of System Intentions that we work with providers in the appropriate contractual forums to identify what contractual intervention are required and plan to put these in place providing the required notice period where contractually this is required.

We need to be clear on the timeline for these changes. We will start planning for 20/21contracts in late September 2019 and it is anticipated that contracts are likely to be signed off early in January of 2020. Work Streams therefore need to initiate discussions with the Contracts team to forward plan these contractual changes as soon as the System Intentions are signed off.

2. Our Population

What is our population like?

We cover an area of North East London made up of the City of London and the London Borough of Hackney.

Despite significant economic growth and regeneration in recent years, City and Hackney faces significant health and wellbeing challenges. Hackney remains one of the most socioeconomically deprived boroughs in England and It is one of the most diverse areas in the country with nearly 90 languages spoken as a main language. (Hackney Borough Profile 2019).

The resident population of City and Hackney in 2018 was estimated at 289,400; the projected population will be 304,600 in 2023 – a growth rate of 5.3% over 5 years (Greater London Authority, 2016).

2.1 Hackney's population

Hackney's population is estimated at 281,700 people. The population is likely to grow to 299,500 people by 2028 and to 351,600 people by 2050 (Greater London Authority, 2016).

Hackney has a younger population than the rest of England, with a higher proportion younger working age adults such as those in their 20s and 30s (City and Hackney Public Health Team, 2018). The proportion of residents between 20-29 years has grown in the last ten years and now stands at just under 20%. People aged over 55 currently make up only 15% of the population. Those aged 65 and over are projected to contribute the most to population growth, with their numbers increasing rapidly in the next decade. This is likely to increase demand for health and social care services in the future.

Ethnicity

As well as a high working age population, Hackney has a high level of ethnic diversity, with 36.2% of the residents identifying as White British, followed by Other White (16.1%) and Black African communities (11.4%). A large and increasing group of residents come from mixed ethnic backgrounds, further increasing the diversity of the borough.

2.2 The City of London's population

The City of London resident population is 7,700 in 2018 (Greater London Authority, 2016) but 360,000 workers' influx daily - this figure is from 2014, it may be more now (The City of London, 2014). The resident population is projected to grow to 9,100 by 2028 and to 10,600 by 2050 – this growth is expected to apply to those aged 65 and over in particular.

The City of London has the highest daytime population of any local authority area in the UK, with hundreds of thousands of workers, residents, students and visitors packed into just over a square mile of densely developed space. The City of London also has the sixth highest number of rough sleepers in London.

Ethnicity

The City of London has a diverse range of ethnicities. An estimated 78% of the City of London population identify as white British; however, approximately 40% of children are from black or ethnic minority groups compared to 21% nationally. The City has relatively small resident population and a large number of service users commute into the area for work.

Across the Boroughs

Public Health in the London Borough of Hackney has a strong relationship with the City of London with a number of public health services commissioned in partnership.

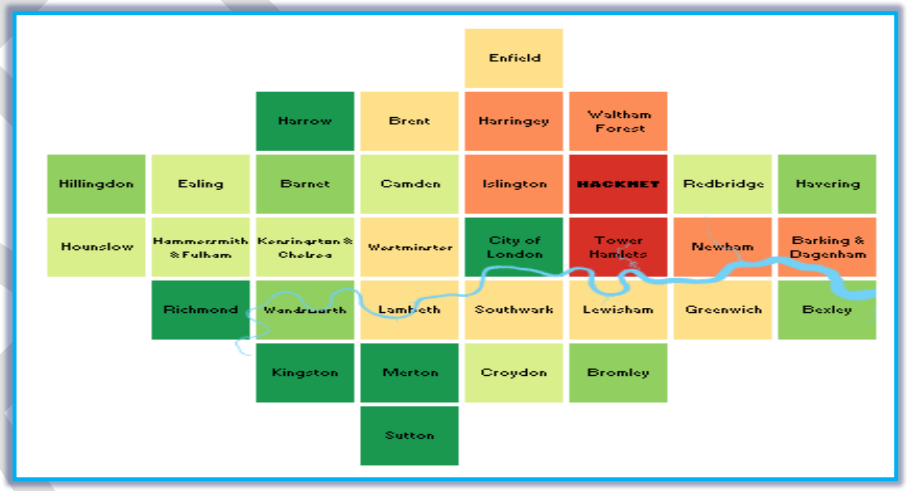
There is high population turnover in the City and Hackney, which can mean frequent new registrations for services. Additionally, ~ 25% of children in City and Hackney were classified as living in a low-income family (City and Hackney Public Health Team, 2015)

In 2017/18, 332,272 people were registered with an NHS City and Hackney CCG GP (City and Hackney CCG, 2018). Applying the resident's growth rate of 5.3%, the total registered population is estimated to be 349,882 in 2023.

The wider determinants

Understanding the sociodemographic profile of an area is important as different population groups have different health and social care needs and interact with services in different ways.

Hackney is the 2nd most deprived borough in London and 11th nationally (IMD2015). The City has lower overall deprivation but significant levels in the east. It is likely that Hackney's relative position will continue to improve overall (City and Hackney Public Health Team, 2015).



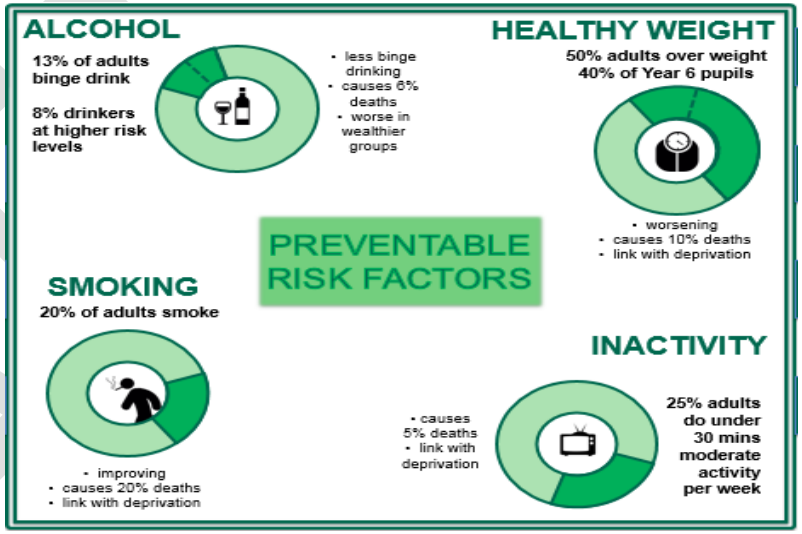
IMD 2015 the redder the square, the higher the deprivation

However, welfare reform impacts on Hackney are high due to deprivation, out of work and in work poverty. (City and Hackney Public Health Team, 2018)

A high proportion of Hackney's population are degree qualified and it has a similar unemployment rate to London. (City and Hackney Public Health Team, 2015) This may explain Hackney's lower than expected all-cause Years of Life Lost rates, given the high level of deprivation (Insitute for Health Metrics and Evaluation, 2018)

Evidence suggests that inequalities adversely affect health across all social strata. Social inequality is likely to increase locally, as wealthier residents move into the area (City and Hackney Public Health Team, 2015) *IMD 2015*

Risk factors



Behavioural

Around 35% of all deaths in Hackney residents are considered to be preventable, or amenable to healthcare – among the highest rates in London (City and Hackney Public Health Team, 2015)

Prevalence of excess drinking is higher in affluent groups, (City and Hackney Public Health Team, 2015) but harms from alcohol disproportionately affect those in deprived areas. (Alcohol Change UK, 2018). Tobacco control is a local health and wellbeing priority. (City and Hackney Public Health Team, 2018)

Clinical

Atrial fibrillation, hypertension and diabetes prevalence are lower in the NHS City and Hackney CCG than England average, much of this is likely explained by the younger population in the area.

3. Communicating & Engaging with our Population

Introduction and context

Each year, NHS Clinical Commissioning Groups (CCGs) are expected to provide opportunities for local members of the public to view and comment on their draft commissioning intentions (CIs) for the year ahead. As opposed to a single commissioning intentions event, the approach for seeking engagement into the 2019/20 and 20/21 Integrated Commissioning System Intentions has been to run a rolling programme of engagement events providing on-going feedback, which care workstreams consider and act upon.

In addition to the above, differences compared to previous years include covering a 2-year commissioning cycle and aligning local intentions with the NHS Long-term Plan and the wider North East London footprint. Therefore, community insights that were gathered through commissioning intentions engagement in the autumn of 2018/19 underpin our local Long-term Plan submission later in the autumn and vice versa – the feedback we have received through our Long-term Plan engagement during this spring informs our review of the 20/21 commissioning intentions. Due to this overlap, we refer to the Long-term Plan/Commissioning Intentions (LTP/CI) in the information below. The time frame, for the purposes of this summary, is October 2018 to the present day.

How we've engaged with local residents

Delivered in partnership with local Health watch branches and communications and engagement colleagues across the Integrated Care System (ICS), engagement activity has been co-produced with user voice groups such as NHS Community Voice, the Hackney Refugee and Migrant Forum, and the Mental Health Advocacy Project as well as relevant care workstreams and representatives.

The approach to LTP/CI engagement in City and Hackney has made use of existing engagement structures and the IC's 'Let's Talk' brand has been used as the umbrella term for all events and meetings. Engagement topics have reflected the Integrated Commissioning Strategic Priorities, the co-produced Priority Themes (designed with input from residents), and key themes of the NHS Long-term Plan.

As of today, 23 events, 3 surveys, 2 focus groups, and a small number of 1-to-1 interviews have taken place across City and Hackney, enabling more than 1,200 residents to have their say on what they'd like local health and care services to look like in the future.

What people have told us so far?

An initial analysis of the emerging themes evolves around concerns about the future of the NHS, the importance of considering the wider determinants of health, the pros, cons and fears around digitalisation and the provision of a holistic, patient-centred care that considers the physical, social, and mental wellbeing of an individual's health, and is delivered locally.

People have told us that they value:

- Our local services but are worried about changes, closures, cuts and the fact that the 'Limited resources' narrative features frequently
- Bringing services back to City and Hackney (e.g. placements for children in care, elderly residents based out of the borough);
- Our long term plans and see as an opportunity, but also as a threat (e.g. privatisation, dismantling of the NHS)
- And are willing to embrace new technologies, but not at the expense of face-to-face appointments with their GP. On the one hand, people want health services to be able to share information and help wrap care around the patient, but on the other hand, they are worried about data protection issues
- A well-co-ordinated and safe out-of-hours services.
- Services that can support people in the community after they are discharged from hospital or specialist care and the role of community and voluntary sector in providing this support.
- Good mental health support for young people, new parents, and the working age population.

'You Said – We Did'

The feedback on 'You said – We did' is collected and this information fed back into the CCG and used to inform the work we do, including defining our commissioning Intentions and improving services. Here are some examples of what people have told us and the actions we have taken.

The feedback documents are also available on the CCG's website **http://www.cityandhackneyccg.nhs.uk/about-us/you-said-we-did.htm**

YOU SAID	WE HAVE (Actions already taken)	WE WILL (Priority actions we plan to take in our Local Strategic Delivery Plan for the City and Hackney System)
Mental health support for young people, new parents and working age population needs to be improved	• Children and Young People have access to the Well-being and Mental Health in Schools (WAMHS) project, First Steps Tier 2 service, and the Five to Thrive (five ways to well-being) initiatives in schools. • Our CAMHS transformation plan includes LGBT work and self-harm follow up in Family Action and Transition work with Off Centre. • We have a two-week accelerated referral process to the Talk Therapies service for pregnant women and their partners. • We have developed 10 Top Tips to support mothers.	• We will improve care co-ordination for young vulnerable people, through implementation of an electronic care planning tool and through the use of digital passports. • We will improve access to a range of therapies for young people. • We will expand ongoing support for people with severe mental illness and complex needs in primary care.

YOU SAID	WE HAVE (Actions already taken)	WE WILL (Priority actions we plan to take in our Local Strategic Delivery Plan for the City and Hackney System)
There is a willingness to embrace new technologies, but not at the expense of face-to-face appointments with their GP. People want health services to share information to help wrap care around the patient but are worried about data protection issues	• The City and Hackney system makes considerable use of Co-ordinate My Care (CMC) beyond its main use for end-of-life care planning, to co-ordinate shared urgent care for patients with dementia, patients on Proactive Care Registers, and nursing home patients. • The Homerton has begun using widespread text messaging of reminders for appointments and is considering IT solutions as alternatives for communication with patients.	• We will continue to make use of telehealth and virtual appointments as part of our Outpatients Transformation Programme.
Access to community based, non-clinical services with a holistic approach is important.	• Our social prescribing service operates in every GP practice in City and Hackney and is working with PCNs to integrate new provision including peer support and group consultation. • We are also developing an IC approach to Speech and Language Therapy. Services will be delivered in a more Integrated way by pooling budgets and creating a programme that can be delivered by one Provider.	• We will continue to pilot work on multi-agency working and holistic models of care through the Neighbourhoods programme.

YOU SAID	WE HAVE (Actions already taken)	WE WILL (Priority actions we plan to take in our Local Strategic Delivery Plan for the City and Hackney System)
Well-co-ordinated and safe out-of-hours services are needed.	• We have developed a wide range of care to keep people out of hospital; these rapid response pathways include step-up care within the re-ablement team (IIT), the Paradoc service, and the Duty Doctor (where a practice-based doctor is always available to see or speak to patients urgently to avoid a hospital visit).	• We will implement an Urgent Treatment Centre (UTC) model so all localities have the same out-of-hospital urgent care provision, with the option of calling the NHS on 111. UTCs will work alongside the urgent care network including primary care, community pharmacists, ambulance services and other community-based services to provide local accessible and convenient choices to help avoid A&E visits.

4. Our local strategic delivery plans

Our local strategic delivery plan and NHS Long Term Plan response

In City and Hackney, we believe that all our residents deserve to live the healthiest and most fulfilled lives possible. Local people and their families want to feel connected to their neighbourhoods, to access high quality care near their homes and in hospital when they need to. Since 2016, we have been working with other organisations who deliver and commission care in City and Hackney to provide better and more joined up services for City and Hackney's residents.

Our local strategic delivery plan is being developed to meet the health and wellbeing needs of local people by delivering the NHS Long Term Plan, and focusing in particular on our local vision and priorities for the necessary large-scale transformation of services over the next ten years. In City and Hackney, our strategic programmes integrate and personalise patient care, empower patients to manage their own health, and provide care which is close to where patients live and work - some of the key initiatives of the Long Term Plan.

Our local system plans include many examples of our commitment to improve quality and harness innovation, and we aim to be innovative too in the way we foster collaboration and integrated working amongst clinicians and partners from different organisations. The main themes of our long term plan and the priorities identified in the NHS long term response include:

- ***Transforming out-of-hospital care and fully integrating community care*:** Through the Neighbourhood Health and Care Services Programme we aim to transform and integrate the provision of out-of-hospital services, informed by whole system workshops held in January 2019.
- ***Reducing pressure on emergency hospital services*:** A really joined-up and integrated local urgent care system: Commissioner and Provider system partners in City and Hackney are working together to deliver an integrated urgent care pathway. This will meet people's urgent care needs, triage and navigate them to the most appropriate place at every entry point into the system, and support people away from the hospital wherever it is appropriate to do so

- ***Digitally enabling primary care and outpatient care***: The City and Hackney system makes considerable use of Co-ordinate My Care (CMC) beyond its primary use for end-of-life care planning, to co-ordinate shared urgent care for patients with dementia, patients on the Proactive Care Registers, and nursing home patients. Due to our local system expertise, City and Hackney represents North East London in the development of CMC at a London level.

  The City and Hackney Directory of Services project will provide a key resource to support more integrated health and wellbeing services in the local system and ensure that care navigation, social prescribing and other interventions are better co-ordinated and supported locally. Work is underway in a number of priority specialties to make use of telehealth and virtual appointments within the Outpatients Transformation Programme. Priority specialties where projects are already underway include diabetes and dermatology.
- ***Giving people more personalised care and control over their own health***: Across services which meet the health, care and wellbeing needs of patients, we have been working to champion strengths-based, person-centred models of care. In our Prevention Workstream we are working closely with our local authority partners and with health and care services. Through a number of programmes, we are implementing training for front line staff in motivational interviewing and other interventions to support and increase patient activation, self-management and choice.
- ***An increasing focus on population health and moving to an ICS approach:*** In September 2019 the Neighbourhoods Programme will take a decision on our approach to population health management tools, including risk stratification and case finding, based on an options appraisal of existing tools and their likely readiness to support integrated care in Neighbourhoods. We continue to work with STP partners on the development of system-wide approaches.

5. Integrated Commissioning Board (ICB) Plans for 2020/21

In-line with our Long term plan, The City and Hackney System intention is focussed on a City and Hackney cross-system planning; Bringing Providers together to better deliver outcomes for our population and as work continues across the system, our aim is to see even closer, more collaborative working between the CCG, Healthcare Providers, Local Authorities and Social Care Providers.

Within our existing contractual relationships, we are already seeking considerable innovation, and will look to extend the identification of cohorts of patients against which we can focus new approaches and means of reducing unwarranted clinical variation wherever possible. As the North East London Commissioning Alliance continues to develop and emerge, this too will influence commissioning activity in the years ahead.

Further details on how we will work as part of an integrated system through our Care Workstreams with our Providers and Partners to deliver these services can be found at the annexed documents.

5.1 The Unplanned Care Workstream

Overall

The unplanned care workstream is part of the integrated care system in City and Hackney. The over-arching workstream objective is to bring together partners to create services that meet people's urgent needs and support them to stay well. This document describes the workstream's objectives which contribute to achievement of the City and Hackney system outcomes.

In order to achieve this, we will deliver the following strategic priorities:

- We will develop strong and resilient neighbourhood services that support residents to stay well and avoid crisis where possible
- We will provide consistent and equitable care across the system, enabled by effective communication and appropriate sharing of information

- We will develop urgent care services that provide holistic, consistent, care and support people until they are settled
- We will work together to prevent avoidable emergency attendances and admissions to hospital
- We will provide timely access to urgent care services when needed, including at discharge
- We will deliver models of care that support sustainability for the City and Hackney health and care system.

The workstream has three main transformation areas through which we are delivering these priorities; **neighbourhoods**, **integrated urgent care** and **discharge**, it also has responsibility for end of life care and dementia.

The following describes what we intend to deliver in 2021:

Neighbourhoods

The neighbourhoods programme is a cross cutting system wide transformation that sits across the workstreams. The areas of neighbourhoods' development that will be driven by the unplanned care workstream are as follows:

- Working with the primary care enabler to support the development of PCNs; recognising that PCNs are the fundamental primary care building block of each neighbourhood
- Ongoing transformation of community health and care services to deliver neighbourhood services. Priorities for transformation are: adult community nursing, adult community therapies, adult social care, community mental health services, and dementia.
- Implementation of an anticipatory care service, which will build on the proactive care services in primary care and will also include wider community partners.
- Working with voluntary sector and borough partners to ensure that neighbourhoods provide the platform for addressing the wider determinants of health through a place based approach. This includes working with prevention workstream to implement an effective model of navigation.

Integrated Urgent Care

We will progress our vision to deliver a joined up urgent care system that quickly navigates people to the right care setting and manages people away from the hospital wherever it is appropriate to do so.

Specific areas of work are:

- Ensuring a direct referral route from 111 and/or 999 into all of our community based rapid response services including Paradoc, Integrated Independence Team (IIT) and Duty Doctor. We will work with LAS to increase uptake of these services.
- Work with the Homerton to continue to realise benefits from being the single Provider for both the Primary Urgent Care Centre and GP Out of hours' services.
- We will work with the mental health co-ordinating committee to review the new High Intensity Users services in order to inform the service model going forward.
- Implementing a sustainable model of streaming and re-direction at the hospital front door (for Barts and Homerton)
- Delivering strong Same Day Emergency Care pathways at the Homerton to reduce the need for admission where possible
- Working with LAS and North East London partners to identify and maximise all opportunities to reduce ambulance conveyances through a strengthened clinical assessment service and closer working between 999 and 111.
- Working with partners across Inner North East London (INEL) to scope the potential benefit for cross-borough provision of primary care out of hours' home visiting services
- Work with partners to continue to realise benefits from effective use of Co-ordinate My Care
- Working closely with our residents to understand what drives peoples use of different urgent care services, and, based on this, delivery of more informed and sophisticated communications to residents. We will work with INEL colleagues to consider where wider public messaging could have more impact.
- Progressing our falls programme, which encompasses both our acute response to falls and working with prevention workstream on falls prevention.
- Working with the planned care and prevention workstreams to develop and improve our respiratory pathways and services

Discharge

We will continue to improve discharge for our residents, ensuring that they can access the community services that they need and ensuring that they do not stay in an acute or mental health bed for longer than is medically required.

Specific areas of work are:

- Work with partners to ensure that our re-ablement and complex discharge teams based in the Homerton are as effective as possible. This includes ensuring that the complex discharge team and IIT work together closely and delivering a sustainable discharge to assess model.
- Identify the specific requirement of homeless people and rough sleepers both during their inpatient stay and at the point of discharge. Work with partners to improve this pathway.
- Continue to deliver effective primary care services to our nursing home residents, and consider whether the new PCN contract provides an opportunity to strengthen this.
- Work with our nursing homes to improve the interface with acute trusts by scoping delivery of a trusted assessor model and the 'red bag' scheme.

End of Life Care

- Sustainable delivery of an urgent end of life care service that supports people to die in their usual place of residence
- Ensuring that our range of end of life services are well connected to our urgent care services so that people receive continuity of care 24/7 and regardless of their access point into the urgent care system.

Dementia

- We will embed the Community Dementia service within the neighbourhood framework and we will work with the Dementia alliance to review the new dementia service in order to inform the service model going forward.

5.2 The Planned Care Workstream

With our partners: Homerton Hospital, East London Foundation Trust, London Borough of Hackney, City of London Corporation, City & Hackney GP Confederation, City & Hackney Community and Voluntary Sector

This document sets out a number of priority areas for service redesign and transformation within the "place based system" for City & Hackney, led by the planned care workstream. It should be read in conjunction with the Planned Care workstream plan on a page and the detailed system intentions developed by workstream team members, including system partners, clinicians and patient representatives. The programme of work has been in development since the workstream inception and has been refined and reviewed for 2020/21 in line with the NHS long-term plan and local developments with our colleagues in the other workstreams: Prevention, Unplanned Care and Maternity, Children, Young People and Families.

The most significant development during 2019 is the plan for a N**eighbourhood Health and Care (NHC) Service** within City and Hackney as the fundamental approach to "out of hospital" services. This Service will alliance provide the framework for a whole range of community services to be transformed to offer integrated, personalised care and support to local residents within the neighbourhood arrangements.

This provides an opportunity for the Planned Care workstream to go further with its **outpatient transformation** programme. We have been transforming the patient journey to outpatient care, reducing unnecessary follow-ups, building on the use of advice and guidance to support primary care and focus the role of secondary care services on those most in need of specialist support. We have already introduced a new virtual fracture clinic, tele-dermatology service and developed a model for increased community gynaecology capacity at the **neighbourhood/primary care network.** We have also increased links to psychological services for people with physical health problems though we can now have, with the NHC services alliance, much greater integration of physical and mental health care in our service models.

In 2020/21 we want to work with our partners in the alliance to build on these developments to redesign our community services to provide increased support within a multidisciplinary context for people with long term conditions. This model will combine psychosocial and medical approaches as well as ensuring links to access to community and voluntary sector services. These services will be an alternative to traditional

models of outpatient care; will focus on delivering a proactive and preventative service to people with **long-term conditions such as respiratory disease, diabetes, chronic kidney disease and dialysis** and be delivered closer to people at the neighbourhood/network level. Work on the use of **anti - coagulants** led by our prescribing team will also support early diagnosis and treatment of people at risk of atrial fibrillation and or a stroke.

We will also, through our NHC services alliance and integrated model, design services that provide a holistic and combined offer that is not limited in scope by funding or contracting arrangements. Our initial proposal is to develop a **women's health service** where we will design a model of care that integrates contraception services, sexual health and gynaecology with women's physiotherapy, mental health and wellbeing services.

Other benefits for our residents are that the new community services will be responsive and will simplify the patient journey either by the use of **digital technology** or by services coming together to reduce the duplication of time and effort for both for the patient and for professionals.

We will also work with our partners to strengthen the **personalisation** of our services and embed approaches to ensure that our residents are **in control of their care, supported to make informed choices and decisions,** provide digital tools to aide **self- management for** people with a long-term condition and **provide the choice of a personal** budget if preferred. People with long term mental health problems will also have access to digital tools to support self-management and will be have access to a personal health budget when appropriate.

Other priorities for people with long term conditions are to redesign **the rehabilitation and recovery pathway for people who have had a stroke** to support people to maximise their independence, are supported to return to work where possible as well access specialist services through the NHC services alliance. Our focus for people with **cancer** will be to ensure that people are **diagnosed early** by their GP and treated promptly on the **62- day cancer treatment pathway.** We will also work with partners in primary and secondary care in implementing the **Faster Diagnosis Standard** by April 2020**.** We will continue our work to **improve screening uptake for bowel cancer** particularly within vulnerable communities and provide more community support for **people in recovery** from cancer treatment.

We have developed a **strategy for all people with learning disabilities**, which we will implement from 2020. The strategy aims to strengthen our approach to personalised services promoting independence, maximising opportunities to meaningful activities, **employment and access to mainstream services** and providing care closer to home where ever possible. We will aim to offer a specific personal budget approach to people with learning disability in support of the new strategy. We are working with the Children and Young People's workstream to strengthen our **Care and Treatment Reviews** and interventions for children and young people with a learning disability or autism. We are also ensuring that our provision of **physical health checks** and action plans for people with a learning disability in primary care is widely available and fully implemented. We would also ask the support of health and social care partners in **making reasonable adjustments** within their mainstream services so that people with learning disabilities and autism are able to access them.

We will continue to support improvements in care for people at home through our transformation plans for the delivery of **Continuing Healthcare (CHC)** which we are working on with our partners in North East London. We will maintain our local focus to support the core neighbourhood team in delivery of CHC and on meeting the national requirements for waiting time to **completion of assessment within 28 days and assessment in the community as opposed to a hospital setting.**

With our local authority partners, we continue to develop protocols for joint funding of care packages and strategic planning for **local nursing home provision**. We are also working on the development of specialist skills and increased capacity in specialist pathways such as mental health and neuro-disability.

5.3 The Prevention Care Workstream

General

We will continue to commission high quality prevention services to achieve our three core (and overlapping) aims to:

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

We will continue with our work to create an enabling environment to embed prevention across the local health and care system, including through our 'making every contact count' programme and joint work with partners to develop a neighbourhood community navigation model (including a re-modelled Social Prescribing service).

Making every contact count

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

Supporting people to take control of their own health and wellbeing

- We will re-commission the existing Social Prescribing service to integrate fully with new PCN provision (funded SP link workers) and align with the new Neighbourhood care navigation model as it emerges.
- We will use the learning from two digital pilot projects (Digital Social Prescribing Platform and Directory of Services) to improve access to, and awareness of, local prevention services.
- We will use the learning from the 'three conversations' innovation site to embed a strengths-based, preventative approach across social care practice in Hackney.

Long-term conditions (LTCs) - earlier intervention

Primary care in City and Hackney has an excellent track record in identifying and managing patients who are at increased risk, or living with, a

range of long-term conditions. However, premature mortality from preventable conditions (including cardiovascular and respiratory disease) remains higher than average locally, and there is more we can do to tackle inequalities through a more comprehensive preventative approach.

- We intend to start work to refocus the LTC contract with the GP Confederation to have a stronger emphasis on incentivising prevention.
- We will review current indicators in the contract, with potential to include/enhance incentives for: alcohol screening and brief advice; reducing variation in referral rates to stop smoking services; COPD and asthma prevalence/case finding; group consultations and self-management; identifying and improving access to support for carers (including linking in to new carer support services in Hackney and the City); implementing annual reviews for other conditions (epilepsy, sickle cell); amongst other things.
- We will also integrate the NHS Health Check contract (also delivered by the GP Confederation) with the LTC contract to optimise and align incentives for CVD prevention in primary care.

Obesity

Collaborative working to tackle obesity locally will continue through a new 10 year strategic 'healthy weight' framework, which has been co-produced with a broad alliance of partners. Providing easy access to targeted support for people at greatest risk of obesity-related harm is one of five shared priorities in the new framework. This reflects priorities within the NHS LTP to take action to improve access to weight management support for adults and children with complex needs/co-morbidities.

- Working with the Planned Care Workstream, we intend to commission a new weight management service to meet the needs of people with complex needs who are not eligible/suitable for bariatric surgery. In designing this service, we will incorporate learning from the Homerton Diabetes Service 'very low calorie diet' pilot.
- We will review current provision of 'lifestyle' weight management services (for adults with less complex needs) and work with partners to develop an integrated adult obesity pathway.
- Working with the CYPMF Workstream, we will undertake a review of the child obesity pathway, with a focus on designing services to meet the needs of children and young people with complex needs who are not eligible/suitable for existing lifestyle weight management

services.

Tobacco

Tackling tobacco dependency within the NHS is a key priority, both nationally and locally. The NHS LTP sets out an ambitious plan to offer all people admitted to hospital NHS-funded tobacco treatment services (through the 'Ottawa' model of bedside support to quit), and a universal smoking cessation offer for long-term specialist mental health service users.

- We intend to embed tobacco screening and brief advice targets as service KPIs from 2020/21, building on progress made by measures put in place by both Homerton and ELFT through the alcohol and tobacco screening and brief advice CQUINs.
- We will collaborate with NEL partners, working in partnership with Homerton and ELFT, to develop a business case to implement the Ottawa model locally.

Alcohol and substance misuse

Whole system action to identify, and take early action to prevent, harmful alcohol use is a key workstream priority, supporting delivery of the new alcohol strategies for Hackney and the City. There are significant opportunities for early intervention in the NHS to reduce alcohol-related harm.

- We intend to embed alcohol screening and brief advice targets as service KPIs from 2020/21, building on progress made by measures put in place by both Homerton and ELFT through the alcohol and tobacco screening and brief advice CQUINs.
- We will complete the re-procurement of a new integrated City and Hackney adult substance misuse service, incorporating service model improvements to better meet the diverse needs of people with alcohol as well as substance misuse, and improve access to mental health support.

Sexual health

- We intend to work with the Planned Care Workstream to develop a collaborative approach to commissioning women's sexual and

reproductive health.

Mental health

Preventing poor mental health and promoting positive mental wellbeing remains a core objective of the Prevention Workstream, with the new Joint Mental Health Strategy setting out our ambitions and how we will achieve these.

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

Learning disability and prevention

We will work with Planned Care colleagues to implement actions on prevention as set out in the new City and Hackney Learning Disability Strategy, in particular:

- To develop approaches to embed 'reasonable adjustments' in mainstream prevention services so they are accessible to people with LD. This is a cross-workstream priority.

Rough sleepers

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

5.4 The Children, Young People, Maternity and Families (CYPMF) Care Workstream

We will continue to work to give our children and families the 'Best start in life' (LTP 2019) by commissioning high quality services, that maximise health and wellbeing outcomes for families throughout the early part of the life course. Alongside delivering quality improvements in our key business areas, we will continue to focus on the transformation of:

1. Emotional health and wellbeing (mental health)
2. The health of our most 'at risk' or vulnerable groups
3. The offer of care throughout maternity and the first 1000 days

We will continue to implement the transformation outlined in the NHS Long Term Plan, particularly across Maternity, CAMHS, and improving our care for children with Learning Disabilities and Autism. We will explore how we can improve access, experience of services and outcomes through use of digital technologies, strengthening prevention and working at scale across with our North East London neighbours (NEL STP) where this gives us the best return.

Specifically, for 2020/21 we will build on the opportunities to strengthen relationships through our integrated care partnerships and more locally, through our multi-agency work at Primary Care Network level.

Maternity

In line with the national maternity transformation outlined in the Long Term Plan, and with our partners across the East London Local Maternity System, we will continue to focus on **quality improvements in service delivery**, building on the improvement trajectory and recent CQC inspection recommendations (August 2018), working toward an 'Outstanding' rating (now 'Good').

Also in line with the LTP aim to accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025 we will continue to roll out the '***Saving Babies Lives Care Bundle'*** and continue to maintain our focus on reducing infant

mortality and avoidable admissions to NICU. This includes being part of the National Maternal and Neonatal Health Safety Collaborative and having a named Maternity Safety Champion.

We will build on our strong trajectory in **continuity of carer implementation**, through the HUFT CQUIN for diabetic women and more generally so that, by March 2021, most women receive continuity of the person caring for them during pregnancy, during birth and postnatally.

We will continue to promote the offer of the **flu vaccination and pertussis** for expectant mothers, as part of the wider City and Hackney 'Improving uptake of immunisations partnership action plan'.

One of our Long Term Plan commitments is to improve access to and the **quality of perinatal mental health care** for mothers, their partners and children by increasing access to evidence-based support. A perinatal mental health offer is in place for women with moderate to severe mental health concerns in the City and Hackney system, as part of work at STP level. City and Hackney have expanded their perinatal service in line with the 2019-20 targets.

We want to agree clear long-term pathways to support women to **access OTC and prescription medicines** throughout the antenatal and post-natal periods, working with Primary Care and Pharmacy.

We will continue to work through Primary Care and our VCS partners to ensure there is **focussed early support**, and a clear pathway for our most **vulnerable women in their pregnancies**, through enhanced checks and education.

We will work toward implementing **digital solutions to support working better** with patients, including maternity digital care records, digital child health information ('e-red book') records, and development of an app to support pregnant women to navigate our services.

We will work closely with our service users through our Maternity Voices Partnership, and wider mechanisms to focus on **improving women's experiences of maternity care.** This includes work with Primary Care around promoting choice.

We will also support **development of care through the neo natal period**, in line with our NICU and would like to strengthen our community offer through HUFT

With the Prevention workstream, we will continue to focus on implementing the **new smoking in pregnancy pathway**, and support the development of the MECC programme, through piloting in the maternity service. We will also begin to scope the need and development of complex obesity pathways for maternity and CYP. This work will be linked to the development of the adult's complex obesity pathway, which is already in development

Children and Young People

In line with the new national Children and Young People's transformation outlined in the LTP, we will continue to deliver on our comprehensive integrated developments locally through:

- Continuing to develop and embed partnership arrangements to deliver **Transforming Care** and preventing the avoidable admission of **CYP with autism and / or LD** who display challenging behaviour to specialist inpatient hospitals. We will strengthen the system wide approach to identification, joint working and monitoring of this cohort, including implementing clear processes for delivery of CTERs (Care, Treatment and Education reviews), across the system. This work links closely with Planned care adult LD and Transforming care work.
- Developing and implementing a system wide approach to raising awareness and reducing the impact of **Adverse Childhood Events**, incorporating three separate workstreams that strengthen workforce, improve the offer of early support and parenting, and develop a digital resource portal to support professionals and carers. As part of this we will consider the development of Adverse Childhood Events education and awareness in primary care, secondary care and in universal services (schools and early year's settings).

With health, education and social care partners, we will review the total **Speech and Language Therapy** budget against the level of need across City and Hackney, including reviewing the CCG and health contribution to the Youth Justice budget (for SaLT). We will develop an

integrated commissioning framework and service model for CYP SaLT provision in City and Hackney, underpinned by pooled budgets between CHCCG, Hackney Council, City of London Corporation and other funding sources.

We will initiate a similar joint review for **Occupational Therapy**, and explore reviewing the commissioning of Learning Disability across the partnership. This is in line with STP priorities around reviewing therapies.

To **improve the Health of looked after children** and care leavers, we will implement an integrated service model for the health assessment, caseload management and nursing provision for looked after children placed by / in City and Hackney, and a comprehensive health offer for care leavers up to the age of 25. We will continue to monitor and evidence the impact of the newly commissioned Health of LAC service model delivering a case management approach with enhanced oversight.

Commissioning a sickle cell mentoring scheme across the STP

With Primary Care, we will recommission **the Early Years' service** recognising the reduction in available funding, and work to develop the coding of CYP with complex needs and including autism, ASD, and LD.

Linked to our wider City and Hackney Immunisations Plan (see above), we will continue to work with the GPC and system partners to **improve childhood immunisation coverage** and childhood flu, utilizing the developing neighbourhood and Primary Care network structures.

We will continue to review the opportunity to **integrate our VCS KIDS and Huddleston short breaks services** with the LA short break services, and decommission the HCA provision from HUHT that supports the KIDS respite play scheme

With the Homerton University Hospital Trust, we will implement recommendations arising from the review of lead professional and key working roles for children with complex needs, in line with the LTP recommendations and continue the development of monitoring and review processes to **support the delivery of SEND requirements**.

We will also review the impact of the community paediatricians to the **audiology** Tier 2 service, and mobilise the reconfigured child health clinics across agreed general practices.

With the Unplanned Care workstream, and in line with the STP, we will explore patterns in **A&E and urgent care attendance** by under 25 year olds, and look at how we might implement learning from successful reduction strategies in adult services.

In line with LTP recommendations we will continue to monitor the new local **paediatric critical care tariff** implementation, and ensure additional support for training is delivered.

In delivering our new safeguarding responsibilities, we will continue to work with partners to **implement the 'Working Together' guidance**, putting in place the new statutory NEL child death review transformation plan. By 29th September 2019 we will ensure that the new operational processes are delivering for City and Hackney, working closely with HUFT to embed these.

Work is beginning to explore the possibility of joining the **0 - 25's** public health, community nursing services (health vising, family nurse partnership, school based health and CHYPS Plus) into one commissioned service. A joint service would likely be commissioned to start in the 2021/22 financial year. For 2020/21, we will continue to commission our strong Health Visiting, School Based health (school nursing) and Family Nurse Partnership services.

Linked to the Prevention work, our **CYP physical activity services** are being redesigned and aligned to other physical activity services in the Council. It is anticipated that the new physical activity services will be commissioned to start in April 2020.

Also linked to Prevention, our Young Hackney **Substance Misuse** Service: The current SLA expires in October 2020, in line with the adult's substance misuse service. As part of the scoping for the design of both the adults and CYP substance misuse services, it was decided that the adults and CYP service would remain separate. The CYP service will be redesigned and commissioned over the next year.

Child and Adolescent Mental Health

Building on a comprehensive CAMHS offer for our Children and Young People, and a robust transformation plan, we will continue to ensure we are implementing the LTP recommendations for improving mental health up to the age of 25, by focussing on:

Development of 24/7 Crisis pathway for CYP and agreeing models for delivery. We will explore options to expand deliver a 24/7 CYP Crisis by expanding the age range of adult services through embedded specialists and training in line with the Gloucester model. The delivery of a 24/7 crisis pathway may also involve collaboration with other CCGs and will be aligned to New Models of Care. Funding is expected to come from NHSE Tier 4 beds savings. In order to commission this, we require information about new models of care and specialised commissioning savings delivered to ELFT.

Eating Disorders: we want to ensure we exceed the national eating Disorders Waiting time and Access targets

Creating **a single point of access** and a work **toward a fully integrated Tier 3 CAMHS service** (including CAMHS disability services) working as a single integrated team.

Developing a comprehensive **18-25 Transitions service** (Tier 2 and Tier 3) in line with national requirements

Developing an **improved offer for the mental health of very young** children (0-5) and their parents which incorporates work from the ACEs project team.

Continuing to roll out our **Wellbeing and Mental health in schools' work** (WAMHS) to all state maintained schools and develop a similar offer to state registered Independent schools that have a majority City and Hackney population. This will be supported by the development of NHSE funded **Mental Health in Schools Teams** from September 2019.

Achieving **viable MHSDS outcome reporting** that reflect accurately the work being done

Clinical Pathway Optimisation: based on the up and coming Demand Vs Capacity review of all our CAMHS pathways work collaboratively to deliver the output / recommendations.

Reviewing our **Youth Justice Pathway Early Help and Diversion pathways,** with our partners across the system

We want to maximise our **digital capability** through implementation of an integrated patient journey management system across CAMHS services. This will include Investment in analytics support to CAMHS and investment in the development of the CAMHs website to support patients and their families.

With our VCS partners, we have secured funding to deliver work to **improve the mental health of Black African and Caribbean heritage young people** at key transition points. We will be supporting our partners to deliver this from late 2019.

5.5 An overview of City and Hackney 2020/21 Mental Health System Intentions

General

The overarching mental health strategy is contained in the draft joint mental health strategy document which has been jointly written by CCG, local authorities, ELFT, VCSE and service user representatives due to be signed of in October 2019. The strategy makes a commitment to 'develop a whole system, all-age approach to mental health in City and Hackney, bringing together the NHS, local authorities, the voluntary and community sector, service users and other partners'. Our strategic priorities are set out in the table below.

Our five strategic priorities:				
Prevention: *We will prevent people from developing mental health problems in the first place, and provide help at the earliest opportunity when they do.*	Access: *We will improve access to mental health support and services, to reflect the diversity of our communities, the most vulnerable and those whose mental health problems are masked by other needs*	Neighbourhood *We will aim to support people in the community wherever we can, working at 'neighbourhood' level with schools, GPs and voluntary and community services.*	Personalisation and co-production: *We will continue to shift power and control to service users, giving them control of their own care and recovery, and involving them in the shaping of local services.*	Recovery: *We will champion the social inclusion of people affected by serious mental health problems, focussing on their strengths and assets, housing, jobs and friendship networks.*

These priorities are aligned to the NHS Long Term Plan (2019) and strategy commits us to achieving *NHS Long Term Plan* aims for mental health including the following key areas:

- *The 'new models of integrated primary and community care for people with SMI, including dedicated provision for groups with specific needs (including care for people with eating disorders, mental health rehabilitation needs and a 'personality disorder' diagnosis)'* will be

principally achieved through the NHSE funded mental health Community Transformation Programme which will create mental health teams in each PCN/Neighbourhood.

- *Personalised care,* will be improved principally through the increase use individualised digital support including online therapies, care planning, navigation and booking; Personal Health Budgets and our commitment to co-produced care planning.

- *Reduced A&E use and admission by people with SMI* with 'complementary crisis alternatives' will be achieved through our continued use of open access crisis services such as the SUN project and the Crisis café and the High Intensity Service User service (HIUS)

- *Children and Young People* with a focus on the Green Paper *Transforming Children and Young People's Mental Health* (2017), will be achieved through our CAMHS Transformation Plan which creates an enhanced role for schools and a comprehensive offer for 0-25-year olds to support transition to adulthood.

Integrated Care

We will continue to focus on integrated approaches to mental health which achieve the triple aim of integration between mental and physical health, primary and secondary care and health and social care. Investment and re-design proposals will continue to be developed workstreams, the Mental Health Co-ordinating Committee and the four mental health alliances Psychological Therapies and Wellbeing, Primary Care Mental Health, CAMHS and Dementia. Through joint contracts and joint working the four alliances have to date delivered significant pieces of transformation and integrated care including a community dementia service, CAMHS transformation in schools, VSO IAPT with BME access and an alliance model of SMI physical heath checks.

There is a need for local authorities and the CCG to continue to develop integrated approaches to 117 and Personal Budgets, the Wellbeing Network, the accommodation and homelessness and substance misuse pathways.

The Mental Health Community Transformation programme which is funded up until the end of 2020-21 by NHSE will enable us to deliver

integrated mental health services within a neighbourhood framework. Key features of the model are:

- The establishment of blended mental health teams, containing East London Foundation Trust and VCSE staff co-located in each PCN/neighbourhood. The teams will be capable of conducting non-urgent assessments and providing care planning, navigation, treatment and support. They will also be integrated within the PCN/neighbourhood with physical health, social care and local community resources. We will review East London Foundation Trusts existing resources
- The provision of a neighbourhood based interventions for people with Personality Disorder and Trauma.
- This will involve additional resources and a review of East London Foundation Trust's existing psychological therapy and allied health professional resources to understand what could be better aligned to a neighbourhood model.
- Through more systematic joint working between GPs and psychiatrists we aim to improve the on-going monitoring of medication for those on SMI QOF and/or on anti-psychotics.
- Co-produced recovery care plans and an enhanced digital offer will support personalisation. This may include the use of online therapy packages which are currently being piloted by East London Foundation Trust working with Silver Cloud. We also explore online care plans and online access and booking systems. Mental health teams will have full access to EMIS and relevant information will be accessible on the EMIS system.
- The programme will shift care from secondary care community teams to the integrated mental health teams in PCNs/ neighbourhoods. Patient flows will be monitored and resources will be transferred from East London Foundation Trust community teams in line with this and the agreed programme plan.
- Both GP and psychiatrists will have responsibility for population based health supported by a neighbourhood level dashboard.

6. The City & Hackney Quality, Innovation, Productivity & Prevention (QIPP) intentions for 2020/21

Whilst commissioning intentions identify key changes that City & Hackney CCG seeks to make to the services next year, the increased demand for healthcare needs to be balanced through the delivery of transformation schemes.

For City & Hackney CCG, the delivery of its QIPP target remains a key priority for 2020/21. The programmes outlined below are a summary of the non-exhaustive areas at various stages of development, from exploring to implementation in progress proposed by the workstreams to ensure delivery of the CCG's net QIPP target of >£5m.

The challenging financial context and the need for QIPP savings in 2020/21 to achieve financial balance suggest that a more transformational approach is required. Hence, the need to work collaboratively to identify new ideas that will help sustain the financial health of the City & Hackney system whilst maintaining and improving quality.

The successful delivery of our QIPP targets will require co-production and proactive engagement from our Service Providers and other partners to support the identification, planning and delivery of CCG QIPP programmes that are currently being developed through the workstreams. These have been identified below:

Planned Care

i. Secondary Prevention Programme – Hypertension Patient Support programmes

ii. Secondary Prevention Programme – Respiratory

iii. Secondary Prevention Programme – Heart Failure Community Based IV Diuretic

iv. POLCE

v. Outpatient Transformation – including C2C *(full year effect)*

vi. Diagnostics

vii. FIT testing - *(full year effect)*

viii. GP Direct Access Pathology – Urea *(full year effect)*

ix. PSA Monitoring GP Shared Care – *(full year effect)*

x. Patient Transport

xi. Non PBR Tariff Service Benefit Review

xii. Primary Care Prescribing

xiii. Outpatient Transformation Virtual Fracture Clinic – *(full year effect)*

xiv. Ophthalmology- *(Full Year Effect)*

xv. GP Referral Variation – *(Full year effect)*

xvi. Tele-dermatology – *(Full Year Effect)*

xvii. CHC Domiciliary Care Brokerage AQP

Unplanned Care

i. Bart's Ambulatory care local pricing

ii. Falls Prevention

iii. End of Life Rapid Response – *(full year effect)*

iv. Non PBR Tariff Service Benefit Review

v. Redirection from A&E Bart's (royal London - Streaming) – *(Full Year Effect)*

vi. Reduction in Local tariff - A&E Streaming Bart's (royal London)

vii. Out of Area Mental Health Repatriation

CYP Mental Health

i. CAMHS Transformation Phase 3 – Demand / Capacity

Sign-off for the City and Hackney 2020/21 System Intentions

Board/ Committee	Date signed off
Unplanned Care Workstream Board	30/08/2019
CYPMF Care Workstream Strategic Oversight Group	19/09/2019
Planned Care Workstream Core Leadership Group	17/09/2019
Prevention Care Workstream Core Leadership Group	06/08/2019
City and Hackney Accountable Officers Group (AOG)- shared via email	25/09/2019
City and Hackney Governing Body	27/09/2019
Local GP Provider Contracts Commissioning Committee (LGPCCC)- (For Information only)	27/09/2019
City and Hackney Patient and Public Involvement (Summary Paper)	11/09/2019
East London Health & Care Partnership operational Delivery Group (ODG)	30/09/2019