City and Hackney Integrated Commissioning - Planned Care Workstream

City and Hackney COVID-19 Response and update on work programmes

Hackney Health Scrutiny Committee

An outline of the work undertaken by the Planned Care Workstream teams.

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Background and purpose

- This paper provides an update to the Hackney Health and Scrutiny Committee on the work programmes of the Planned Care Workstream within City and Hackney Integrated Commissioning structures

- The context for the report has clearly been affected significantly by the Sars Covid 19 Pandemic and the associated work programmes have adapted to both respond immediately to the crisis and to re-frame the planning of future developments to reflect the need to restore and recover services in a 'covid secure' manner

- Much of the work in recent months has been governed through the oversight of the System Operational Command Group for City and Hackney, chaired by Tracey Fletcher and has linked with the Emergency Planning arrangements with Hackney and the City as well as the Public Health Team

In keeping with the broad remit of the Planned Care Workstream this report covers:

- Elective recovery including outpatients and surgical pathways
- Recovery of Cancer services
- Primary care developments and management of services for people with Long term conditions including recovery and rehabilitation for people who have been affected by Covid 19
- Community services and PCNs
- Medicines management
- Services for people with Learning Disabilities
- Continuing healthcare
- Accommodation and support for rough sleepers during the pandemic

The report outlines the impact of the pandemic on previous plans, delivery of successes, plans for recovery of services and plans for Winter and the impact of health inequalities across all of the work areas.

Elective care: Outpatients, Diagnostics and Surgery and plans for recovery

In March 2020 at the beginning of COVID-19 pandemic, all routine hospital elective; surgery, diagnostics, Face to Face outpatient appointments and community service appointments were suspended.

Primary care access was restricted and referrals were possible but cancer or urgent referrals were being seen. All referrals were clinically triaged and prioritised or deferred.

During the low activity point of April/May, the activity fell as shown below compared to the average
* Much of this activity has become virtual rather than face to face.

Activity	Pre COVID Average	COVID Low Point	Percentage (of average)
GP Routine referrals	4645	411	9.0%
GP 2ww referrals	1052	479	46.0%
First Attendances	6531	2283	35.0%
Follow Up attendances	13364	6021	45.1%
Elective (Daycase)	1598	175	11%
Elective (ordinary)	232	29	12.5%
GP Consultations	332,233	186,051	56%

Note: GP activity may not be exact due to the way it is recorded. However, it indicates the scale of change. (CEG)

Current planning for elective recovery

NHS England set 8 tests with 12 expectations to guide the response of London Integrated Care Systems (ICS) on the recovery and restoration programme. (See appendix 1)

This was followed with a set of national expectations for phase three of the pandemic response from Sir Simon Stevens to accelerate the return to near-normal levels of non-Covid health services, making full use of the capacity available in the ‘window of opportunity’ between now and winter.

This requires the NHS to:

Restore full operation of all cancer services.

Recover the maximum elective activity possible between now and winter

The following targets have driven the plans for recovery of services:

In September at least 80% of their last year’s activity for both overnight electives and for outpatient/daycase procedures, rising to 90% in October (while aiming for 70% in August);

90% of last year’s levels of MRI/CT and endoscopy procedures, with an ambition to reach 100% by October.

100% of last year’s activity for first outpatient attendances and follow-ups (face to face or virtually) from September through the balance of the year (and aiming for 90% in August).

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Current planning for elective recovery 2

In response to the requirements of the 8 tests and the phase 3 letter the three acute Trusts in North East London, Barts Health NHS Trust (BH), Homerton University Hospital Foundation Trusts (HUH) and Barking Havering and Redbridge University Trust (BHRUT), have come together to form an acute alliance to lead the recovery of acute elective care services.

The acute alliance will deliver the following:

- Inclusive and equitable restoration of elective surgical services and diagnostics
- Inclusive and equitable restoration of cancer services, including screening
- Winter planning that includes preparedness for future peaks in CoVID, critical care and general acute bed capacity.
- Acute workforce planning to address workforce pressures, enable new models of elective care and support any plans required to address winter and/or additional CoVID peak/s

Plans have been submitted to NHSE for a

- return to 89% business as usual (BAU) levels of Day Case and elective activity by October. Within this, both Barking Havering Redbridge University Trust (BHRUT) and Barts Health (BH) are planning a return to 90% by October, Homerton University Hospital (HUH)is just below at 87%.
- return to 90% BAU levels of diagnostics by October.
- return to 96% of new and 98% of follow up outpatient appointments by November. Within this, BH is planning a return to 100% by October, and HUH is planning a return to 100% for follow ups by September.
- to have significantly reduced our 52 week waiters from 5608 in August, down to just below 2500 by end March.

Current planning for elective recovery 3

- Elective and day case capacity has been reduced significantly in order to meet the Infection Prevention and Control (IPC) guidance. Plans are based on assessment of what can be delivered within current infection control guidelines and of where utilisation can be improved to maximise the usage of current capacity.
- Plans are based on the following green capacity across the three trusts from September: 49 elective theatres, 683 overnight beds, and 164 day-case beds.
- Homerton are maximising utilisation of their green day surgery unit including developing a new short stay (23 hour) ward and use of extended sessions.
- Homerton main theatres are within the main hospital so they are unable to fully utilise them for elective work.
- Barts Health have refocused orthopaedic and ophthalmology services at the Gateway Centre at Newham and Whipps Cross Hospitals respectively to concentrate low acuity high volume activity in the most appropriate hospital settings within the Group in line with our surgical strategy.
- Cancer surgery has continued at close to BAU volumes at St Bartholomew's Hospital. Daycase activity has been phased away from the Royal London Hospital to other hospitals within the Group to maintain capacity for the higher acuity work undertaken at the Royal London Hospital. However, this is anticipated to cause acute bed pressures at the Royal London Hospital for inpatient elective work.

All trusts BAU position included a significant volume of additional weekend and evening sessions that were required to support waiting list management.

The step up to delivering 89% elective and DC activity is being delivered through:

- Increased theatre capacity from additional theatres becoming operational
- Increased productivity enabled through the new IPC guidance
- Expected reduction in refusals and DNAs from the new IPC guidance
- Widespread use of weekend and evening lists

Current planning for elective recovery 4

Plans are also in place to deliver of low acuity, high volume elective procedures in four hubs across the Alliance. This will ensure standardised, optimised delivery of surgical specialties across North East London.

- The alliance priorities are to establish orthopaedic and ophthalmology hubs through September 2020. The orthopaedic hubs are at Newham University Hospital and King George's Hospital, whilst the ophthalmology hubs are at Whipps Cross and King George's Hospital.
- Plans for further hubs for gynaecology, general surgery, ENT and urology are in train. The hubs for gynaecology and general surgery will be established at King George's Hospital and Homerton University Hospital. The hubs for urology and ENT at Whipps Cross and King George's Hospital. The clinical leadership arrangements and supporting management input are currently being finalised.
- The Trusts have established a NEL diagnostics hub to oversee the restoration of all imaging across the sector.
- Dual working is the norm to maintain clean vs dirty segregation especially with mobile X-Ray. This practice is reflected in all local data and Trusts have agreed the same operating capacity of 60% when dealing with either positive or mixed patient cohorts. The only green scanner is CT at BHRUT.

In Outpatient services infection control guidance and the need for social distancing have required the three trusts to dramatically reduce the volume of patients within clinics and to radically re-think how to deliver outpatient care. A significant volume of appointments have moved to a digital or virtual model though some patients do necessitate a face to face visit.

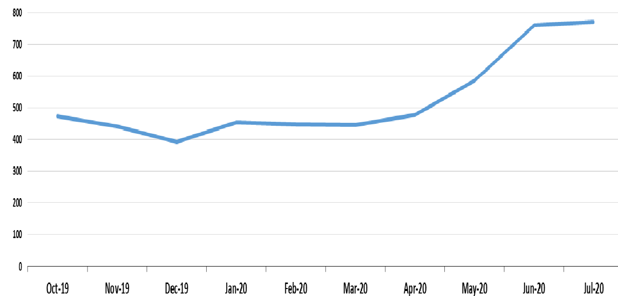
In order to deliver face to face activity, the following has been undertaken:

- Spreading clinics across acute and community estates in order to minimise the number of people attending one reception and waiting room
- Routine use of weekend and evening sessions to spread activity across the day
- In City and Hackney we are working this through our existing Outpatient Transformation Partnership and exploring opportunities for initiatives such as Patient Initiated Follow up and increase community capacity for specific long term condition pathways. We are also actively working with the Trusts to ensure that the impact on residents and patients of all these changes are clearly communicated as this is extremely important – especially in the context of digital exclusion, health inequalities and concerns about transport and potential impact of self isolation requirements prior to procedures etc.

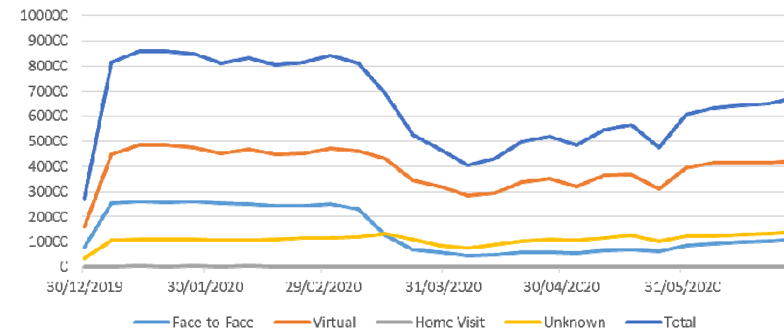
Other elective recovery 5

Advice and Guidance

Average activity more than doubled during COVID-19



GP Consultations CEG



HUH Referral activity (unpublished)

	Pre-COVID Average	27-Jul	03-Aug	10-Aug
Total	2326	1790	1629	1820
Percentage	100%	77%	70%	78%

Virtual Activity – July 20

Trust	% Virtual (Total)	OPFA Virtual	OPFU Virtual
Barts Health	93.6%*	25.1%	74.9%
BHRUT	39.2%	30.5%	69.5%
HUH	31.5%	13.2%	86.8%
NEL	72.7%	24.9%	75.1%

GP Consultations	Pre-COVID	Current Position
Face-to-Face	30%	15%
Virtual/Telephone	56%	64%
Home Visit	0.4%	0.3%
Unknown	13.6%	20.7%

Note: GP activity may not be exact due to the way it is recorded. However, it indicates the trajectory and scale of change. (CEG)

Cancer screening recovery

Reports for Sep 2020

Cervical screening recovery

All invitations have restarted and screening has resumed and are being sent at >100% of the usual rate.
NHSE are developing plans to support additional capacity –extended hours, sexual health clinics.
Also working up a pan-London social marketing campaign.
88% of NEL practices are now sending samples to CSL. Practices who have not restarted screening are being contacted.
The number of samples sent from NEL practices increased by 50% in the two weeks to 2ndAugust compared to the two weeks to 19thJuly.
All women who have received an invitation should be screened.
Communications about this have been sent to practices.
Cervical Screening London (CSL) are seeing a week on week increase in samples received.).
No longer restrictions on screening women who are low grade being invited for colposcopy or follow-up.
Colposcopy recovery plans have been approved by NHSE.
Most units will struggle with capacity and will need support to expand services to meet demand.

Breast screening recovery

All sites have been formally approved to resume screening.
Open invitations will be sent from 30thSeptember until March 2021.
This will be reviewed in December.
The pan-London Breast Screening Recovery Board has been stood down while NHSE lead implementation of a recovery plan
The DNA rate is low, but not all appointment slots are being filled.
Extended opening hours of call centre.
Calls increased to 4000 in July, but well below usual numbers of 30k per month.
There is capacity to cope with a further increase in calls to the hub resulting from open invitation letters.

Bowel screening recovery

Routine invitations have restarted in all screening centres.
The hub is seeing an increase calls and returned FIT kits, but these are still below pre-Covid levels.
Bowel Scope–this was suspended and unlikely to resume. Patients had been invited, but not screened.
Patients invited for BowelScope will most likely be sent a FIT test.

Inner North East London

NEL are 15 weeks behind on invitations –have requested an increase to their invitation plan.
Backlog of FIT positive patients almost cleared. There are a few patients who are still not willing to come in or would prefer to wait for the service to restart at Whipps Cross in September.
Negotiating with Spire for two lists per week for Waltham Forest patients who do not want to travel too far –this will increase lists from 5 to 7 per week.
Invitation rate will be increased when Whipps Cross service resumed.
Plan to catch-up by early January 2021.
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Cancer recovery 2

Cancer performance has been achieved at Bart's Health and Homerton University Hospital in June 2020. Barking Havering are on track for achieving 2ww referral compliance for August 2020. There is anticipated decline in performance as the providers see patients waiting for diagnostics. The numbers of patients waiting over 63 and 104day+ have continued to reduce . Key recovery actions coordinated by the NEL Cancer Alliance are:

- Weekly cross system COVID-19 recovery meetings to ensure system-wide approach and support for restoration of cancer services
- Work with providers and systems to ensure sufficient screening, diagnostic and treatment capacity at NHS sites and in IS providers to meet rising demand in 2ww.
- Implementation of national infection control guidance to further release capacity
- Enhanced local communications to reduce inequalities in access of services targeted to patients, carers, primary and secondary care and with partner organisations (CCG's PCN's, PHE, Cancer Charities, Local authorities, Health watch, community organisations etc..) about services being open, and activity encouraging patients to use primary care, screening, diagnostic and treatment services
- Further development of the Rapid diagnostic centre models.
- Opening of Mile End Early Diagnostic Centre will increase endoscopy and ultrasound capacity
- Decrease endoscopy demand through utilisation of Faecal Immuno Testing (FIT) and CT-colonography (CT-C)
- Increasing NHS endoscopy room availability in green zones
- Increase utilisation of endoscopy – via implementation of new IPC guidance, increased sessions per NHS site, cross system workforce and Independent Sector utilisation
- Recruitment of additional staff to support delivery (including additional clinical fellows funded by HEE and the alliance). Medium to long term staffing challenges supported through HEE endoscopists development programme
- Additional kit to maximise delivery
- Longer term - development of diagnostic hubs

Cancer recovery 3

NEL Patient Tracker (PTL)Summary

6,545 undiagnosed patients with suspected cancers are on the PTL, 4.3% increase over past 2 weeks.

820 of 6,545 patients (12.5%) fall into one of the COVID related delay categories. Capacity it sited as the most common delay reasons at 10.7%(699).

7of 207 diagnosed patients (3.4%) fall into one of the COVID treatment categories. Capacity is sited as the most common delay reason at 1.9%(4).

Updates dated 20th Aug 2020

Barts -Summary

2,862 undiagnosed patients with suspected cancers are on the PTL, 4.7%increase over past 2 weeks.

444 of 2,862 patients (15.5%) fall into one of the COVID related delay categories. Capacity sited as the most common delay reasons at 14.8%(424).

5 of 72 diagnosed patients (6.9%) fall into one of the COVID treatment categories. Capacity is sited as the most common delay reason at 5.6%(4).

Homerton -Summary

641 undiagnosed patients with suspected cancers are on the PTL, 16.5%increase over past 2 weeks.

31 of 641 patients (4.8%) fall into one of the COVID related delay categories. Capacity is sited as the most common delay reasons at 3.9%(25).

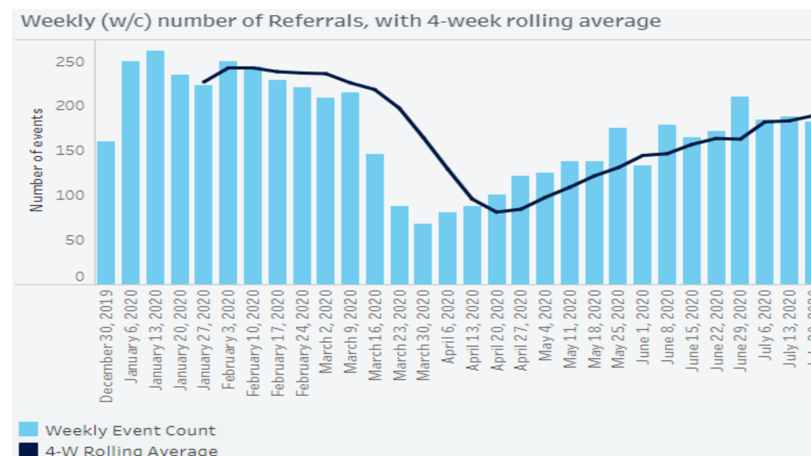
2of 48 diagnosed patients (4.2%) fall into one of the COVID treatment categories, with Patient choice and Clinical Risk sited as the delay reasons.

No diagnosed patients had treatment delays due to capacity constraints.

Cancer recovery 4

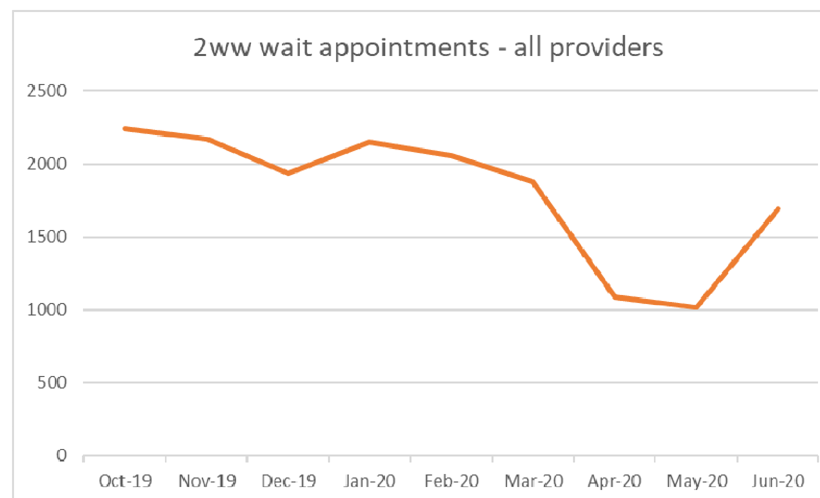
Activity Recovery (City and Hackney)

GP Referrals (2ww e-RS) – All Providers



2ww wait referrals are steadily increasing to normal levels

2ww First Appointments attended (SUS) – All Providers



Latest published data indicates slower recovery but increasing as capacity has been reopened. Expect July & Aug to show further increase towards normal levels

People with long term conditions (LTC) in the community

During the Covid Pandemic, we suspended our usual primary care LTC contract and activity and replaced it with a focus on vulnerable people. We prioritised people with COPD and Asthma, diabetes, hypertension, heart failure, Learning Disabilities and Severe Mental Illness in higher risk groups. We developed new clinical pathways to help primary care teams to prioritise those most at risk and care for them largely remotely. This including scripted conversations and links to wider support such as the LBH humanitarian assistance helpline and social prescribing. Over 2000 reviews were conducted in this project.

We also linked to various parts of the system to help with welfare calls to vulnerable residents and other support services (such as linking the ACERs respiratory team with the Shoreditch Trust offer of food support). Colleagues at LBH co-ordinated a VCSE-led Covid response with a single point of access which included our social prescribing team as a core member of.

We provided education and advice to practices via our clinical leads on carrying out virtual reviews and supporting patients to access technology. We also rolled out virtual group consultations training and support offer to practices

Currently we are working with the GP Confed to stand back up the LTC primary care contract with detailed advice on prioritisation and adjustments due to Covid. We are also working with our communications team on encouraging patients with LTCs to optimise their health before the winter season by attending review appointments.

Our next steps are to focus with public health and clinical leads on disadvantaged groups and people with higher risk profiles to ensure they are prioritised and managed ahead of any second wave. This Includes consideration of remote monitoring opportunities and potential to increase capacity in specialist teams embedded with primary care (diabetes, heart failure, respiratory) and / or primary care for additional support.

In light of the phase three requirements and Outpatient Transformation opportunities, we are developing alternative approaches to hospital services / enhanced specialist outreach to support community / primary care and maximise LTC management in the community alongside the neighbourhood team. One example of this is our Heart Failure iv diuretics project – delivering intravenous medication to enable people to stay in their own homes rather than be admitted to hospital. Project Manager post (0.5 wte) to be appointed to work on specific pathways such as renal, respiratory and stroke to further pursue this model.

Recovery and rehabilitation from Covid 19

This is an emergent piece of work we are now coordinating through Planned Care. In order to determine the level of need and requirements for local services and in line with national policy guidance our activities include the following

- Consideration of the Post ICU snapshot and post hospital attendance audits undertaken by the Homerton. This assessment of need is complimented by a Primary care audit we have commissioned which is due to be completed by mid-September. It aims to (establish the potential numbers of people with enduring symptoms and types of support needed.
- We have also developed a CEG template to support post-covid pathway and coding in primary care our local work has been presented to NEL Clinical Advisory Group (CAG) as blueprint for services in NEL. We have been encouraged to continue at pace to ensure services are in place quickly for those in need now and produce a clear and timely service offer.
- We are managing this work with a multi-stakeholder steering group set up – including rehab professionals, primary and secondary care clinicians and commissioners which is reporting to the System Operational Command Group (SOC)
- We have finalised an Integrated Care Partnership breathlessness pathway which will be launched via GP education event on 25th September
- Proposal for a business case for a local comprehensive service is in progress and will utilise existing services with enhanced capacity / skills as far as possible. The model is based on hierarchy of needs and functional impact with essential primary care assessment / triage into other levels of care with advice and guidance. More complexity will be managed by multi-disciplinary assessment (virtual) to direct patients to appropriate pathway and acting as a single point to refer into. The model will also include group education and a peer support offer.

Next steps will require:

- The development of the clinical pathway and detailed service offer (including Advice and Guidance to primary care, virtual group education, psychological input and chronic fatigue service enhanced offer). To include assessment and triage process; referral thresholds into each service element and outcome measures.
- The business case whilst identifying current services and new requirements will take into account non-Covid waiting list of rehab patients
- Communications strategy ensuring all relevant stakeholders are involved – including a range of specialist clinicians
- Proposal for wider workshop style meeting to engage with system partners (including social care and voluntary sector) once further detailed services outlined
- Return to NEL CAG – each area to do a stocktake of current services and proposals
- NEL Out of Hospital group to co-ordinate a minimum standards service offer to ensure equity across NEL

Community services and PCNs

Community Health Services (CHS)

- All services should be available for referral
- Most offering virtual first but should now have capacity for face to face where needed
- We are aware of pressures on some services e.g. Foot Health waiting list of over 1000 priority patients – we are working with the Homerton on plans to address these waiting lists

- **Other services**
- Termination of Pregnancy – full service throughout COVID-19
- Audiology – providers back receiving referrals and face to face services back on line
- ENT – now operating again from Nightingale Practice
- Minor Eye Conditions – operated virtual and face to face throughout
- Additional capacity for 'shielding patients' has also been modelled to support practices at PCN level to provide home visiting for key minor diagnostics such as blood tests and blood pressure checks. This can be reinstated in response to an increase in Covid cases if required. We have also issued a number of BP machines for patients to self monitor

NHS England are supporting the roll out of **First Contact Practitioner in Primary Care** Networks by providing funding towards these roles until at least April 2024. We have been able to progress with this initiative.

- First Contact Practitioner (FCP) services ensure that, where appropriate, patients with musculoskeletal (MSK) conditions are seen by the right person in a primary care setting and they receive appropriate care in a more timely manner. This primary care role improve MSK pathways, improve onward referral practice and enhance patient experience and outcomes. They will reduce demand on GP appointments for Msk conditions, releasing capacity for other more complex patients and provide overall efficiencies across the Msk pathways.
- To enable a system approach the CCG has collaborated with the 8 PCNs and the GP Confederation to commission a service from the Homerton Hospital. This has enabled faster recruitment and should lead to a sustainable service for the long term across City and Hackney and to achieve maximum benefits for the patient and system.
- The first FCP was recruited and in place at Hackney Marshes PCN from July and as of September 2020, there are now 11 FCPs in post out of the 16 half time roles required. This means that all 8 PCNs now have at least one part time FCP in place. The FCPs are already seeing patients and being developed in the role and local GP network.

Work programme of medicines management team 1

- March 2020 the CCG MMT suspended most routine prescribing activities. Practice Support Pharmacists (PSPs) were redirected to support our local patient population by providing additional support to our primary and secondary care colleagues. This involved having a more active involvement in medicines information queries, supporting supply of medicines via hospital virtual clinics, and increasing the uptake of electronic repeat dispensing in primary care. NHS England and NHS Improvement advised practices to prioritise putting all suitable patients on electronic repeat dispensing as soon as possible. PSPs were utilised to support implementation of this work. In June 2020 C&H only had 2 out of 40 practices below target for electronic repeat dispensing and 22 practices in City and Hackney above target. There was also an increase in prescriptions sent electronically (EPS) which increased from about 82% (Jan2020 end) to 96%
- To ensure safe medicines deliveries to vulnerable patients using volunteers, MMT led amulti-agency programme of work involving Volunteer Centre Hackney (VCH), the neighbourhoods team and the Local Pharmaceutical Committee. This included the MMT developing a standard operating procedure (SOP) which was then converted into a set of infographics for both community pharmacies (CPs) and volunteers. VCH offered support to both individual patients and to community pharmacies that were unable to meet the increased demand for deliveries. A total of 5025 prescriptions were delivered across City and Hackney via this service. This service was successfully stood down in August 2020.
- Additional support was provided to Community Pharmacists (CPs) as they remained open throughout the pandemic and particularly in the early stages were encountering substantial problems. This support included co-ordination of supplies of PPE, participating evening zoom sessions and disseminating information from national and local calls to coordinate a streamlined approach to medicines across the boroughs.
- C&H CCG already commissioned a service to support access to end of life care (EOLC) medicines which provides 24/7 access, However, during the pandemic with EOLC in the community considered a key priority, there was substantial amount of extra work including, amending EOLC stock lists to align with the NEL guidance for EoLC symptom control both in terms of increasing the range of medicines and the volumes; developing additional pathways to improve resilience for accessing these medicines. A major concern was that EOLC medicines would become unavailable due to the increased demand so there needed to be close monitoring of medicine availability. There were also a number of national and pan London EOLC documents launched, the most important being a new pan London Medicines Authorisation & Administration Record (MAAR) for use with injectable EOLC medicines in both adults and children. This supports patients to receive high quality symptom control when they pass away in the community. This required extensive work with training stakeholders, agreeing pathways and implementing appropriate communications. The chart was launched in mid-August and there are so far no reports of any problems.

Work programme of medicines management team 2

- Anticoagulants are medicines which slow down the blood clotting process and are used to support the prevention of clot development. They are used for several different clinical conditions. Warfarin is an anticoagulation that requires blood monitoring to ensure safe and effective treatment. The City & Hackney GP Confederation developed a Home Visiting Service for Warfarin Monitoring during COVID-19 Pandemic. The home visiting service for warfarin monitoring was a new model of care, delivering anticoagulation management to vulnerable patient groups identified as needing to shield. The service covered the total population of patients registered with City and Hackney GP practices for the period of the pandemic whilst patients were required to shield. Patients were proactively reviewed to be transferred from secondary care into primary care for care closer to home. Patients were also reviewed by anticoagulation hub clinics for switching onto alternative anticoagulants that require less routine monitoring. This work is ongoing.

- The Primary Care Network Contract Directed Enhanced Service (DES) states that from October 2020 PCNs must use appropriate tools to identify and prioritise the PCN’s Patients who would benefit from a Structured Medication Review (SMR). The CCG MMT are currently working closely with the C&H GP Confederation (who are representing the PCN Clinical Directors) to enable this work. The aim of this meeting is to highlight the need for resources to help support deliver the SMR DES. Official guidance from NHS England is expected in October 2020. The CCG have also entered into early stage discussions with the Clinical Effectiveness Group (CEG) regarding supporting this work stream. Future work includes future proofing digital support to help PCN pharmacists and clinicians proactively identify patients for structured medication reviews. This will help reduce unwarranted variation and help standardise best practice.

- The CCG Medicines Management Team established a Primary Care Network Pharmacists’ (PCNPS) development programme in January 2020. The MMT had highlighted that the PCNPs are critical to ensuring medicines optimisation is effectively managed in City & Hackney. After consulting with Primary Care Networks (PCN) Clinical Directors it was agreed that the development sessions would be reprioritised with sessions used to upskill PCNPs to better manage the COVID response. PCNPs have now had training from specialist pharmacists in respiratory and diabetes medicine. The next session will be jointly run with the Clinical Effectiveness Group and focus on upskilling PCNPs to identify at risk patients and delivering virtual patient reviews.

Work programme of medicines management team 3

- In response to impact on COVID-19 on care homes, NHSE issued a letter requesting commissioners and primary care providers to support care homes. The CCG's lead for care homes set up a local care homes working group with key stakeholders. The MMT undertook a baseline review to identify any gaps in meeting the four medicines asks from NHSE. Informed by national & regional NHSE virtual meetings, The MMT have provided a support offer to care homes. The MMT continue to work closely with the care home group in order to deliver this key programme of work. The MMT has also provided a package of support to PCN pharmacists delivering SMRs in care homes through training updates, answering queries, signposting to national/local resources and the setup of clinical huddles to discuss cases. The MMT have also set up a dedicated care home resource page on the CCG intranet and based on feedback from care homes the MMT have arranged training sessions on medicines management topics. The MMT are currently focusing on continuing the work on structured medication reviews (SMRs) that are delivered for care homes. Work on delivering the NHSE asks re medicines optimisation for care homes has been developed alongside the NEL STP Medicine Optimisation Care homes working group in line with the 'do once' across NEL approach.

- City and Hackney MMT presented a hypertension project in the Public Health England Cardiovascular disease 2020 conference. The project was aimed at reviewing and improving blood pressure in black patients (African or African-Caribbean origin) with uncontrolled hypertension (>140/90 mmHg) by optimising treatment, identifying if there were any reasons for non-adherence to antihypertensive medication and providing lifestyle advice through pharmacist led hypertension clinics. The need for this work was identified after noticing that African or African-Caribbean patients have a much higher prevalence of hypertension and subsequent cardiovascular disease, stroke, renal failure and dementia and therefore the potential risks associated with uncontrolled blood pressure are greater for this patient group. Data from the Clinical Effectiveness Group showed that blood pressure is well recorded across the population in City and Hackney. However the data shows that 5% of black patients have an uncontrolled blood pressure of >150/90mmHg compared to 2.5% of non-black patients. Black populations also appear to have uncontrolled blood pressure and/or abnormal blood pressures at an earlier age. The intervention was a pharmacist led consultation to work with and empower patients to identify reasons for their uncontrolled hypertension. The hypertension review project demonstrated that using targeted pharmacist led consultations to review hypertensive patients can lead to an improvement in systolic blood pressure control. One of the main reasons leading to a reduction in systolic pressure was an improvement in adherence to antihypertensive medication. This project highlighted the importance of drilling down data to identify differences in health outcomes for patients of different ethnicities. With a better understanding of the multifaceted nature of health inequalities and the need for targeted interventions, there is greater potential for improving unwarranted variation. The planned care team are keen to build on this pharmacist led model to deliver targeted reviews to improve health outcomes and help reduce health inequalities in other long term conditions. Projects are currently being considered in diabetes and building on the hypertension work. NICE accepted this project as a good case to share via it's shared learning work: here: https://www.nice.org.uk/sharedlearning/pharmacist-led-hypertension-review-project-in-black-african-or-african-caribbean-origin-patients

Services for people with learning disabilities

People with learning disabilities have poorer health than non-disabled peers the LeDeR (mortality) review programme have been established to understand avoidable inequalities and improve the standard of care. In the wake of the Covid19 pandemic such issues have been brought to the fore.

In the Covid19 pandemic, the **Leder programme** saw the number of notifications increase by more than double compared with the April in previous years, with North East London seeing four times more with 39 cases. 5 of these are City and Hackney people with another case was reported in June 2020. Four of these six cases were Covid related.

Covid19 rapid reviews were undertaken where Covid19 contributed to the cause of death to ensure timely learning across NEL. Key learning points included:

- seeking hospital assistance early
- Need for improved communication of Covid diagnosis and accurate testing.
- Access to Personal Protective Equipment, especially within supported living schemes.
- Hospital passports provided vital information.

Annual Health Checks:

- The number of patients on the learning disabilities register has increased by 7% since March 2020.
- 22% of patients on the Learning Disability Register over 14 years old have received an annual health check between April - June 2020. Work is ongoing to achieve the 75% target.
- A welfare check template was developed and used by GPs during the pandemic to support learning disabled people and similar checks were undertaken by the Integrated Learning Disability Team.
- A new Annual Health Check template is being piloted by GPs in City & Hackney.

We are developing a proposal to enhance our support with additional clinical leadership and capacity to the community in working with people with a learning disability and embed the learning from the Leder reviews. Winter planning measures are also being put in place e.g. a campaign promoting the uptake of flu vaccinations, to help prevent future ill health within this population. This also includes a focus on digital exclusion risk and plans to mitigate any possible impact from this.

Progress on **joint funding** programme for the Integrated learning disability service has been impacted by the pandemic but has continued. This is an major programme work which has resulted in over £2m of additional health monies invested in care packages for this population. We expect the programme to conclude by December 2020 and to become a BAU process. Reports on this programme and the implementation of the strategy for people with learning disabilities will be presented at the Integrated Commissioning Board in October 2020.

Continuing Healthcare 1

- At the start of the COVID-19 pandemic, NHSE published national guidance to expedite the safe discharge of patients from acute hospital beds. The temporary measures put in place stopped all continuing healthcare (CHC) assessments from taking place; however, no one had to contribute to their care as the NHS paid for it. Under COVID arrangements, the Hospital Discharge Single Point of Access team managed discharges and the Local Authorities commissioned either a package of care at home or an interim placement within a care home. The exception to this is that the Continuing Healthcare team continued to arrange care for individuals at the end of life (fast-track).
- The letter from Simon Stevens on 31 July 2020 "Third phase of NHS Response to COVID-19" confirmed the Government decision to resume NHS Continuing Healthcare assessments from 1 September 2020. Additional discharge guidance and CHC guidance published on the 21 August 2020 describes the processes required from this date. From 1 September 2020, health and social care partners must fully embed the discharge to assess processes. The government will fund new or enhanced health and care support for a period of up to six weeks, following discharge from hospital. During this period, a care act or continuing healthcare assessment must take place.
- The Government will continue to provide funding to support timely and appropriate discharge from hospital in line with new updated Hospital Discharge Service Requirements.
- The reintroduction of CHC guidance identifies two streams of work:

  NHS CHC work deferred between 19 March and 31 August 2020 (Deferred Assessments)

  Routine NHS CHC referrals, starting from 1 September 2020
- The CCG is now working with our local authorities to review the list of patients discharged from hospital between 19 March 2020 and 31 August 2020 to determine who will need assessment for CHC eligibility. This will include prioritisation of need. Partners are also developing a recovery plan detailing a trajectory of how the deferred assessments, deferred reviews and all new referrals can be progressed based on previous joint working practices and any resource requirements. There is a national requirement to report on this plan bi-weekly.

Continuing Healthcare 2

Estimated total of Deferred Assessments for NELCA	WEL	BHR	C&H
Est. patients requiring CHC assessment (up to Aug 20)	470	934	160
Est. patients requiring a Review	292	1187	44
Total assessment and review	762	2121	204
Budget allocation (K)	800	688	269
Budget/assessment and review (K)	1.05	0.32	1.01

- There remains a plan for a North East London CHC transformation programme; however, there are delays to this work due to COVID.
- We have an ambition to deliver CHC at scale where it makes sense and brings benefit to residents. It is important to ensure equity of provision across NEL. Our preferred approach is to deliver most of the back office functions at this level. We intend to build our local service to reflect the needs and structures within our own emerging integrated care partnership.

Rough sleepers and homelessness

Context: in response to COVID-19, local authorities and the City were required to provide fast track accommodation for all rough sleepers

- The GLA, Healthy London Partnership (HLP) and local authorities all procured additional accommodation to meet that need.
- LBH procured 2 hotels and additional accommodation- providing beds for around 170 rough sleepers
- The GLA commissioned accommodation was used by local authorities and the City- it housed 20 rough sleepers linked to LBH
- The GLA is now transferring residents into local authority and the City accommodation- working with Housing Leads . LBH have commissioned 2 hotels near Finsbury Park and are moving rough sleepers into these sites to provide more stable accommodation
- There has been a national commitment to ensure rough sleepers find stable accommodation- 'Everyone in for Good'. However there continues to be uncertainty about how to fund this- with bids being made to central government

Health Services response

- An ELFT Outreach Service has been commissioned to provide health assessments, GP registration support, and general primary care- the team is made up of 2 GPs and 3 nurses- it covers Inner North East London. A review is underway to understand what service is needed in the medium-long term.
- The UCLH Find and Treat Team have been providing COVID-19 testing and other general care
- A COVID-19 Hotel, based in Newham, was used where rough sleepers presented with COVID-19 symptoms
- The Public Health Team have been helping coordinate the CRISP health assessments- with assessments being completed in all hotels- results to be released shortly
- The GLA have commissioned a mental health support service for Rough Sleepers- called RHAMP- it's a 2 year pilot with outcomes to be assessed following the pilot
- The Planned care team have instigated a City and Hackney Rough Sleeper and Health Partnership Group to coordinate service planning for rough sleepers. The C&H Group are currently reviewing future proposals for rough sleepers as part of phase 3 planning and ensuring maximised links with the HLP/GLA partners.
- North East London have also appointed a lead commissioner to help coordinate planning with the other North East London boroughs. The focus will be on learning from the health assessments undertaken and planning services accordingly

Appendix 1 - The 8 tests

Meet patient needs			Address new priorities		Reset to a better health & care system		
1. Covid Treatment Infrastructure	2. Non-Covid Urgent Care	3. Elective Care	4. Public Health Burden of Pandemic Response	5. Staff and Carer Wellbeing	6. Innovation	7. Equality	8. The New Health & Care Landscape
Maintain the total system infrastructure needed to sustain readiness for future Covid demand and future pandemics	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Quantify the backlog; act now to slow growth in backlog as much as possible; develop the plan for clearing over time	Identify the risks; act now to minimise as much as possible; develop the plan for mitigating post pandemic	Catalogue the interventions now in place; identify additional actions now to support staff; develop the plan for recovery	Catalogue the innovations made; determine those to be retained; evaluate; plan for widespread adoption	Understand the needs of people and places who are the most impacted by inequalities and co-create models based on what matters to them	Catalogue the service and governance changes made and made more possible; deliver the new system
(e.g., capacity and surge capability in primary care, critical care, equipment, workforce, transportation, supply chain; strict segregation of health and care infrastructure; treatment innovation; role of the Nightingale)	(e.g., reductions in presentations; reduced access for cancer diagnostics and treatment; implications of screening programme hiatus; care for those with long-term conditions)	(e.g., prevention and community-based treatment, the rapid increase in 52 week waiters and the overall RTT backlog; major increase in capacity to diagnose and treat; use of independent sector for waiting list clearance)	(e.g., mental illness, domestic violence, child abuse, other safeguarding issues, lack of exercise, economic hardship; retaining the positives such as handwashing/ acceptance of vaccination, air quality, greater self care for minor conditions)	(e.g., meeting physical and psychological burden; developing a "new compact and a new normal" for support to staff in social care, primary care, community care, mental health, critical care, acute care settings; BAME staff and carers a particular priority)	(e.g., virtual primary care. outpatients, remote diagnostics, new approaches to triage, workforce models, use of volunteers, remote working, pace and urgency to decision making, financial models)	(e.g., capturing the right data to inform service design, need models of identifying and reaching out proactively to meet need; integrated health and care approaches to addressing inequalities)	(e.g., stepping up the new borough-based ICPs; domiciliary and residential care infrastructure; configuration of specialist services; governance and regulatory landscape implications; streamlined decision-making)
#1 We retained resilience to deal with on-going Covid 19 and pandemic needs	**#2 We did everything we could to minimise excess mortality and morbidity from non Covid causes**	**#3 We returned to the right level of access performance for elective cases prioritised by clinical need**	**#4 We put in place an effective response to the other effects on public health of the pandemic**	**#5 We helped our people to recover from dealing with the pandemic and established a new compact with them**	**#6 The positive innovations we made during the pandemic were retained, improved and generalised**	**#7 The new health and social care system that emerged was fundamentally better at addressing inequalities**	**#8 The new health and social care system that emerged was materially higher quality, more productive and better governed**

Appendix 1: The 12 expectations

1. A way of operationalising strict segregation of the health & care system between covid and non covid and a much stricter separation between urgent and elective work especially by site, with international best-in-class infection prevention and control practices
2. A permanent increase in critical care capacity and surge capability, centred on tertiary sites
3. Virtual by default unless good reasons not to be: primary care, outpatients, diagnostics, self care, support services
4. Triage/single points of access/resources and control at the front end of pathways e.g., through sector-level PTLs for all pathways prioritised by need and "talk before you walk" access to keep people safe and best cared for
5. New community-based approaches to managing long term conditions/shielded patients
6. New approaches to minimise hospital stay to that which is required to meet needs e.g. discharge models which maintain reductions in DTOCs/Long Length of Stay, same day emergency care, community-based rapid response
7. Disproportionate focus and resources for those with most unequal access and outcomes
8. Further consolidation and strengthening of specialist services
9. A single, more resilient ICS-level platform for corporate support services and further consolidation and sharing of clinical support services
10. New integrated workforce and volunteer models and new incentives to drive the behaviours needed to deliver these new models of care
11. Further alignment and joining together of institutions within the ICS
12. A new approach to consent through systematic deliberative public engagement e.g. citizens juries

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Appendix 2: Referral to Treatment Times (RTT

C & H 18 week performance is significantly down with specific issues in dermatology, ENT, plastics and orthopaedics. Latest unpublished data (Aug) indicates that the Homerton are improving overall waits and surgical areas are the most problematic. (RTT Target is 92%. CCG pre COVID average 90% plus)

City and Hackney RTT – June Published

Specialty Compliance	PTL	RTT Performance	Median Wait in Weeks
CARDIOLOGY	707	62.8%	15.0
CARDIOTHORACIC SURGERY	54	74.1%	9.5
DERMATOLOGY	889	42.6%	19.4
ENT	994	47.0%	18.5
GASTROENTEROLOGY	691	67.7%	13.1
GENERAL MEDICINE	90	66.7%	15.8
GENERAL SURGERY	1161	51.3%	17.8
GYNAECOLOGY	1554	61.3%	16.1
GERIATRIC MEDICINE	105	64.8%	16.8
NEUROLOGY	262	78.6%	7.9
NEUROSURGERY	165	48.5%	18.8
OPHTHALMOLOGY	1588	51.9%	17.8
ORAL SURGERY	0		
OTHER	5135	62.1%	15.9
PLASTIC SURGERY	176	28.4%	23.6
THORACIC MEDICINE	501	80.0%	7.3
RHEUMATOLOGY	262	70.6%	14.4
TRAUMA & ORTHOPAEDICS	1172	40.1%	19.7
UROLOGY	953	54.9%	17.2
Total	16459	67.1%	16.7

Average weeks wait	***HUH Unpublished Data***		
Treatment function	29-Jun	27-Jul	31-Aug
Cardiology	14.9	15.4	14.5
Dermatology	18.6	18.5	18.9
Ear, Nose & Throat (ENT)	15.4	15.8	14.8
Gastroenterology	13.3	11.2	10.5
General Medicine	15.8	15.9	14.1
General Surgery	17.9	18.3	17.4
Geriatric Medicine	14.7	15.1	12
Gynaecology	14.9	13.7	12.8
Neurology	7.3	4.8	4.3
Ophthalmology	15.5	15.1	15.7
Plastic Surgery	20.5	19.8	17.9
Rheumatology	13.1	12.9	9.8
Thoracic Medicine	11.2	10.9	10
Trauma & Orthopaedics	19.8	20.5	18.9
Urology	16.1	16.5	14.8
OTHER	15.3	15.5	14.1
Grand Total	15.8	15.7	14.5