Integrated Care Partnership Plans

Improving Health and Wellbeing for the residents of City and Hackney

- Restoring and improving care after the first COVID peak
- Summary of our preparedness for winter
- Planning for recovery and second wave: Managing safety, risk, capacity and flow

NHS Homerton University Hospital NHS Foundation Trust

City & Hackney GP Confederation A community interest company

#FairerHackney hackney cvs

NHS East London NHS Foundation Trust

City of London

Hackney

NHS City and Hackney Clinical Commissioning Group

November 2020 v2.1

City and Hackney Integrated Care Partnership Priorities

The integrated delivery plan is based on cross-cutting themes (focused around life courses) and covering the major programmatic areas of integrated health and care provision. It has been developed by mental health, primary care, social care, community health and voluntary sector organisations working in partnership.

#	Priority Initiatives	
1	**Theme 1:**	**Children, Young People, Families and Maternity**
	Priority 1:	Address increased risks associated with **safeguarding vulnerable children** presented by the pandemic and its economic and social consequences
	Priority 2:	Expand and adapt current and future **CAMHS** and other provision to better meet specific community-based **family mental health and emotional health and wellbeing needs**
	Priority 3:	A community-specific, long-term strategy to turn around our historically low local take-up of **childhood immunisations**, building on recent achievements
	Priority 4:	Further integration of support for **disability and additional needs** which pro-actively responds to recent significant increases
	Priority 5:	Achieving **quality improvements in maternity** and adapting to direct and indirect COVID risks
	Priority 6:	Continuing to develop whole-system **support to families** which addresses inequalities and builds more effective partnerships with communities and the voluntary sector
	Priority 7:	Ensuring that multi-agency work and **service delivery models in Neighbourhoods** link effectively with services and strategies for children, young people, maternity and families
2	**Theme 2:**	**Neighbourhoods and Communities**
	Priority 1:	Ensuring that all primary and community and voluntary **services in Neighbourhoods are accessible and safe in the context of the coronavirus**, and that we have suitable plans in place to reduce the impact of seasonal flu and a potential second wave
	Priority 2:	Implementing **new models of care across different services and organisations** to promote more personalised, joined-up, holistic and preventative care delivered in Neighbourhoods
	Priority 3a:	Developing a range of **urgent and rapid response services** which allow residents to be treated closer to home, and to reduce time spent in hospital
	Priority 3b:	Improving **support to people in crisis** or in distress; reducing the rising admission on psychiatric wards and mental health A&E attendance
	Priority 4:	**Addressing a wider range of people's mental health and wellbeing needs at home**, within primary care and through culturally appropriate local community resources, and supporting people with Severe Mental Health Illness and personality disorder in the community through MH community transformation and expanding digital access
	Priority 5:	Restoration of elective activity and reducing the numbers of people waiting for care as a result of the coronavirus pandemic including **proactively focusing targeted interventions on those residents with long term conditions who are most at risk**
3	**Theme 3:**	**Rehabilitation and Independence**
	Priority 1:	**Better integrating the health and care offer to residents in care homes and residential settings** as a local system, including more proactive support by primary care, and better support for testing and infection prevention and control
	Priority 2:	Ensuring that the 'in for good' approach taken to **support homeless people and rough sleepers** is maintained and built upon
	Priority 3a:	Building on **effective discharge processes** while maintaining consistent and effective discharge and continuity of care for residents
	Priority 3b:	Ensuring that we **improve end-of-life care** within our health care system, including all age psychological support for families in relation to bereavement
	Priority 4:	Developing new pathways and services for **residents with long term rehabilitation needs after COVID-19**
	Priority 4b:	**Supporting people with dementia** by improving diagnostic rates and developing the community dementia hub outreach programme
	Priority 5:	Ensuring that we proactively monitor and **address the additional needs of particularly vulnerable patients** such as patients with learning disabilities and patients most likely to be adversely affected because of inequalities resulting from the pandemic, including digital integration of care and digital inclusion
	Priority 6:	**Addressing the impact of the pandemic on depression and anxiety** by expanding IAPT access, including access for people with LTCs

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Restoring and improving care after the first COVID peak

From February 2020 like all of the NHS, City and Hackney has faced unprecedented challenges and changes to the way we work in response to the COVID-19 crisis. Working in partnership with other ICPs across NEL and the wider London STPs, we have focused our business and resources in working together to manage the crisis.

At the end of March 2020, System Operational Command (SOC) arrangements were established in City and Hackney to provide a coordinated emergency planning and resilience response across the local health and care system during the pandemic. SOC's priorities continue to be the restoration and safe delivery of services in the context of the ongoing pandemic.

As an Integrated care partnership, we are working together to meet the needs of our local population moving from the crisis footing of Phase One of the NHS response to COVID-19 into Phase Two 'restoration and recovery' where efforts were directed at making sure that local health and care services are accessible and safe in the context of the pandemic response. Phase Three is focusing on accelerating the return to near- normal levels of non-COVID health services, preparation for winter alongside possible Covid resurgence and taking into account the lessons learned during the first Covid peak; (e.g. beneficial changes, action on inequalities and prevention).

Given historic winter pressures and cases of Covid-19 continuing to rise, it has been announced that London is now classed as 'high' risk (or 'tier 2') under the government's new Covid-19 local alert system.

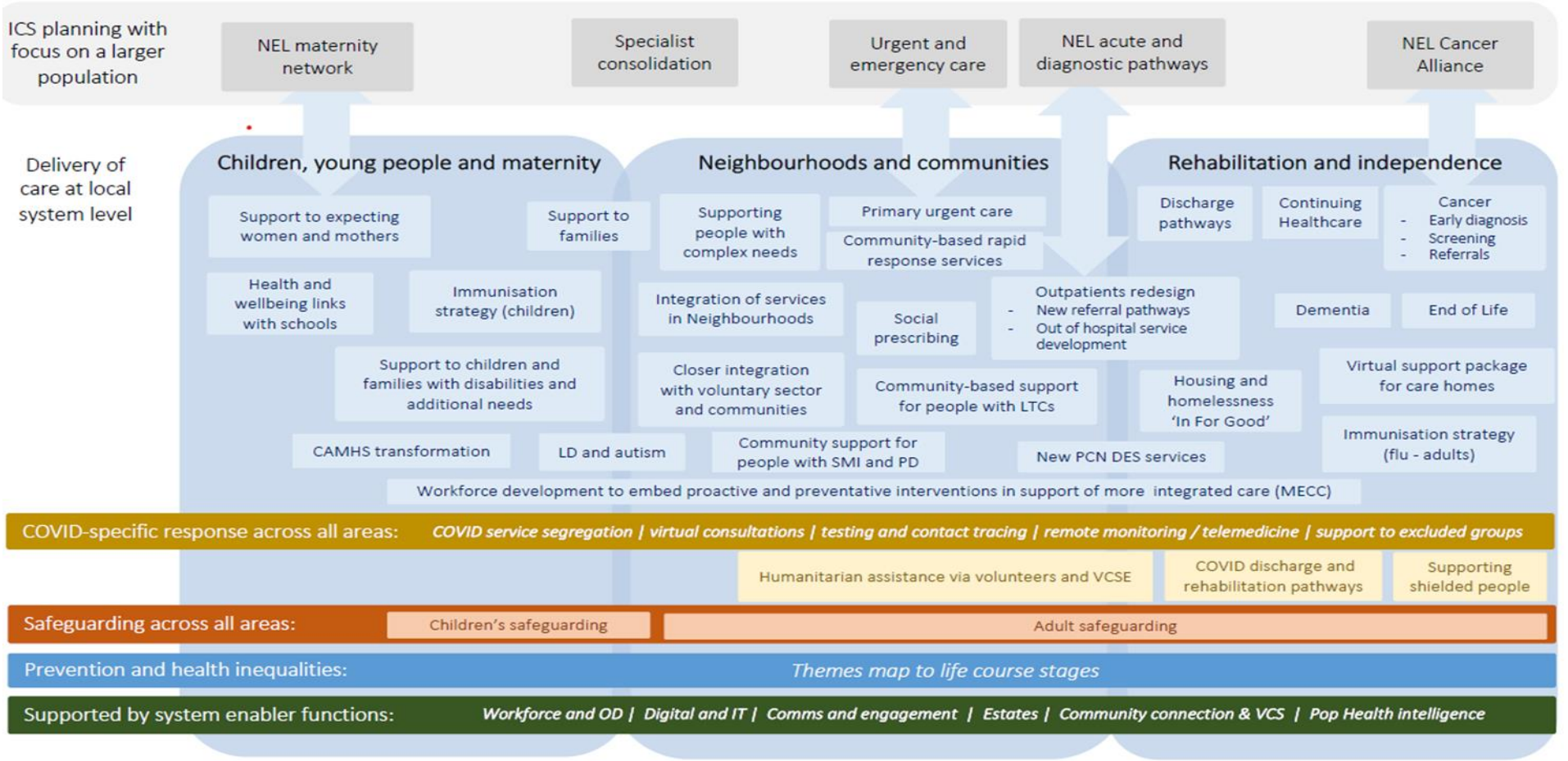
As such, SOGG has aligned areas of delivery along four programmatic areas of integrated health and care provision which will be delivered by local mental health, primary care, social care, community health and voluntary sector organisations working in partnership. These areas include Children, young people, families and maternity; Neighbourhoods and communities; Rehabilitation and independence and The Strategic Enablers.

The priorities for these four areas of delivery have been aligned according to three key activity areas which include: Service redesign in a COVID context; Winter planning 2020/2021 and Delivering on our LTP & integrated care ambitions.

This document presents the combined health and social care system approach to improving the health and well being of our residents and represents the Hackney and City position.

Restoring and improving care after the first COVID peak

The SOC high- level plan details the major programmatic areas of integrated health and care provision which will be delivered by local mental health, primary care, social care, community health and voluntary sector organisations working in partnership



Working Together - What's worked well and learning from our Covid-19 response

- A renewed focus on population health and place based partnerships
- Buy-in and support from partners, including from the education, adult social care, homeless, community and voluntary sector
- Effective joint working across Hackney and the City
- Good leadership with a clear and well communicated governance structure
- Good systems and responsiveness to interpret public health intelligence and changing data from Public Health England and the Department of Health and Social Care
- Knowledge of and investment in community and voluntary sector partners, with good co-design, governance and peer advocacy to support engagement, relationships, networks and communications
- Consistently strong multi-agency working
- COVID-19 work strengthening existing working relationships and building new ones, improving data integration goals and opening up data across the system as standard practice
- Developing a whole suite of standard operating procedures (SOPs) to demonstrate our preparedness effectively to local businesses, organisations and communities by having these published, reviewed and used in a timely manner
- Rapid mobilisation of local contact tracing to support the NHS Test and Trace service where they have not been able to make contact with a local resident.

Restoring and improving care after the first COVID peak

Working Together - Progressing as Partners through the pandemic

- The Public Health Commissioning Team has maintained management oversight of all Public Health contracts throughout the Covid-19 response. Initially focusing on lockdown implementation, this has now moved on to the safe reopening of services, including understanding and mitigating the adverse impact of safe reopening practices on certain groups of residents e.g. those unable to access an online only service offer.
- Maintaining continual communication and feedback loop across all Service Providers and regular updates provided on Covid-19 response.
- Strategic oversight of repurposing of services commissioned e.g. Community Kitchen providers were allowed to suspend all cook and eat classes and focus instead on the delivery of meals to vulnerable residents.
- Enhanced contract management has also been implemented with all providers receiving a contract review meeting in Q4 2019/20 and Q1 2020/21 and this has continued to be monitored for both quarters.
- As part of system preparedness, carrying out a series of COVID-19 virtual desktop exercises as part of the City and Hackney ongoing outbreak response.

Service Delivery

Our expectation has been that our providers develop service delivery plans that are as close as possible to what they were originally commissioned to deliver whilst also being compliant with the Covid-19 guidelines. This has meant that in situations where clinically appropriate, a virtual offer is being provided. Some face to face services have continued:

- Where this can be done with safe social distancing e.g. outside walking groups.
- In certain limited circumstances to address a specific need e.g. on two occasions our IRIS service provider agreed to meet a client at risk of DV in a GP practice when the client could not safely access the service any other way.
- Some critical health services where a risk assessment has been completed and a service cannot be delivered any other way. This includes School Nursing safeguarding assessments, health visitor appointments and HIV testing for vulnerable outreach clients for the HIV Support Service who cannot access the available e-service due to their vulnerability and/or lack of resources.

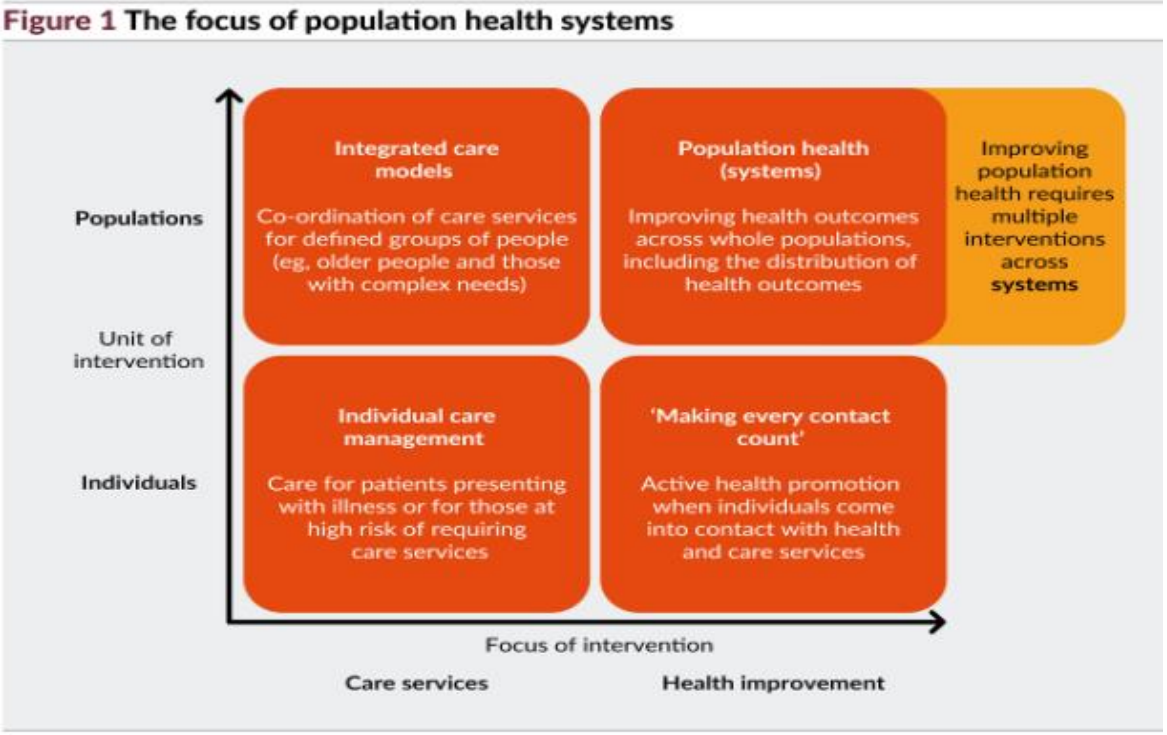
The renewed focus on addressing the existent health inequalities in our society

- Covid-19 pandemic has exemplified and exacerbated some of the health inequalities experienced by our residents. There is a renewed priority focus by the Partnership to address this issue. The City and Hackney strategy regarding this can be found within this presentation.

Restoring and improving care after the first COVID peak

Managing Population Health & Tackling Inequalities

Figure 1 The focus of population health systems



- Health inequalities are **avoidable** and **unfair** differences in health status between groups of people or communities and are defined according to a number of different dimensions.
- Covid-19 pandemic has exemplified and exacerbated the long-standing health inequalities City and Hackney residents experience.

- The direct health impacts of COVID-19 disease are disproportionately affecting certain minority ethnic groups, older people, men, people with underlying health conditions (esp multi-morbidity), care home residents and staff, those working in other public facing occupations, as well as individuals and families living in socially deprived circumstances.
- Untangling the contribution of these various overlapping risk factors is complex, but it is clear that underlying structural inequalities are playing a role.

- The indirect health impacts of lockdown and social distancing and the longer-term economic consequences of the pandemic will continue to affect some of our most vulnerable residents and communities for a long time to come - including many of those described in the box above, as well as carers, certain faith communities, people with disabilities and those with no recourse to public funds.
- There is emerging evidence that women have been more likely to be furloughed or made redundant following the lockdown, and the longer-term social and economic impacts on already disadvantaged children and young people are also expected to be significant.

Managing Population Health & Tackling Inequalities

Governance

Establishing a Health Inequalities steering group to advise, prioritise, authorise, coordinate and mobilise local action as part of a system-wide health inequalities plan for the City and Hackney

Initial focus on

- A short term action plan to mitigate some of the inequalities felt in the first wave of Covid19
- How we will know this approach is working – what are our measures of success?

Health and Wellbeing Strategies

- City of London and Hackney HWBs have agreed to adopt a population health framework when drafting their new Health and Wellbeing Strategies
    - Using the Kings Fund 4 pillars of population health, as well as local principles of shifting balance of power, sharing responsibility and creating opportunities
- City and Hackney Integrated Care Board have adopted the same framework to develop a population health delivery plan
- Health Inequalities steering group will support the two (CoL and Hackney) HWB strategy groups to develop a framework for the 2 Health and Wellbeing Boards (Hackney and City of London) to draft their Health and Wellbeing Strategies (coproduced with residents)

Inequalities toolkit

- Defining tools we need to help embed health equity considerations into all policy and practice across the City and Hackney and work with relevant groups/partners to develop them.
- Working with programme leads across system to embed use of these tools.

Restoring and improving care after the first COVID peak

Managing Population Health & Tackling Inequalities

Four broad areas for action have been defined based on a range of these different sources of information which include:

- City and Hackney Health and Wellbeing Profile (the 'JSNA')
- Community insight gathered by various local partners prior to and during the pandemic
- Local data on the distribution of coronavirus infection and COVID-19 outcomes
- Local/NEL data on inequalities in service use during the pandemic
- The Public Health review of the evidence of COVID-19 inequalities impacts (last updated in July)
- National data and evidence (including from PHE, the Health Foundation and the Institute for Fiscal Studies).

Prevent/mitigate health inequalities associated with the direct impacts of the pandemic		Address wider, long-standing health inequalities	
1. Prevent & control future outbreaks	2. Reduce inequalities impacts of COVID19 disease	3. Reduce inequalities associated with the indirect impact of the pandemic response	4. Renewed action on the social, economic & environmental determinants of health

We are currently mapping existing work across C&H on health inequalities within these four areas (and using this to identify gaps and opportunities for more work). We will use this to develop a short-term action plan for the C&H system to prevent/mitigate health inequalities impacts of future outbreaks/second wave (including the work already underway/planned through the Health Protection Board and SOCG) that can also be shared and communicated with stakeholders (and potentially residents).

Restoring and improving care after the first COVID peak

Children, Young People and Families : *Safeguarding our vulnerable children*

Key strategic activities underway / planned / needed to contribute towards this area

- Phase 2 mitigations to support this group continue (fortnightly MDTs, Health Visitor rapid response service, increased face to face reviews), reviewed in September 2020
- Work at STP level to support the new Child Sexual Assault (CSA) hub through a well-being pathway and paediatric resource contribution. Delivery through local partnerships work to address the needs of children who are vulnerable to sexual exploitation. The London Borough of Hackney is a (DfE) pathfinder delivering work on contextual safeguarding
- Targeted work undertaken to ensure face-to-face health reviews for LAC are up-to-date especially children placed outside of Hackney
- Throughout the pandemic, the CHSCP Strategic Leadership Team has maintained oversight of strategic risks and contingency arrangements for individual agencies.

Current key areas of discussion include:

- Community engagement and actions for the safeguarding partnership as a whole going forward and focus on the risks and opportunities post lockdown
- Development of partnership strategies to address increased demand, including on health services
- Across the health economy a NEL risk register captures a range of risks which is managed via the local safeguarding governance structures. Risk register is updated on a monthly basis and submitted accordingly to NEL and NHSL
- Changes to the Child Death Review process continue to be implemented including the procurement of Family Liaison Service to undertake the keyworker role to support children and their families. The CCG has also secured additional funding for the Homerton to recruit a Child Death Review Nurse to support the Designated Doctor for child deaths
- Increasing return to face-to-face work for services such as Health Visiting and children's social care

Key risk / issue areas flagged to SOC ….

- Concerns around the increased safeguarding risks (e.g. domestic violence), number of head traumas and accidental falls from windows, and general emotional wellbeing following COVID
- Continued increase in numbers coming into care, including unaccompanied asylum-seeking children with effects of PTSD, and the associated increase in demand on staff capacity

Restoring and improving care after the first COVID peak

Children, Young People and Families : *CAMHS and family mental health / emotional health and wellbeing needs*

Key strategic activities underway / planned / needed to contribute towards this area

- Phase II of the crisis service now operational, providing a 7-day service (9am-9pm) that offers emergency, community-based assessment and treatment, in addition to a 24/7 crisis line
- Rollout of Wellbeing and Mental Health in Schools (WAMHS) complete in most schools (83%)
- Mental Health Support Teams (MHSTs) in half of schools now (from September 2020)
- DfE Wellbeing for Education Return was rolled out to schools via the CAMHS Alliance
- Funding agreed to provide a mental health offer to the Orthodox Jewish community in response to the impact of the pandemic
- Communications plan developed to ensure awareness of mental health support for children and families
- The CAMHS Alliance supported with infection control information as part of 'back to school' work through developing an SOP for schools and outreach settings and worked closely with the Local Authorities to publish ‘back to school’ resources
- Fast tracking of virtual resources such as Kooth, an anonymous online counselling platform for ages 11-19
- Successful completion of the 16-25 Off-Centre transition service is now being put forward for recurrent funding
- A COVID-related bereavement service has been commissioned by the CCG from St Joseph’s Hospice
- The draft Integrated Emotional Health and Wellbeing Strategy (2020-2025) has been refreshed taking account the impact of the pandemic and will be out for consultation by December 2020
- We are leading the ‘Improving outcomes for Young Black Men’s Mental health workstream’ with a range of partners. Action plan underway.

Key risk / issue areas flagged to SOC ….

- Remains a paucity of real-time data across the CAMHS Alliance – difficult to predict / manage any surges in demand when relying on quarterly returns
- Difficult to predict the demand / capacity due to return to schools and ongoing. We are expecting a surge in demand.

Restoring and improving care after the first COVID peak

Children, Young People and Families : *Strategy for childhood immunisations in the context of the pandemic*

Key strategic activities underway / planned / needed to contribute towards this area

- Continued focus on childhood immunisations across City and Hackney to address historically low rates, including:
  - 2-year integrated partnership action plan to increase uptake of immunisations across all age groups, reported directly to ICB
  - A partnership task group, led by Public Health, focused on areas such as a local publicity campaign (including bus stop posters and 'back to school' campaign)
  - A GPC commissioned service in NE Hackney
  - GP forum on childhood immunisations planned for early November
  - Strong immunisations message and signposting throughout published Early Years settings resources

- Childhood immunisations and nasal flu immunisations for 2- and 3-year olds are included in a combined children and adults GPC contract Childhood immunisations delivery likely to commence in January 2021 following concentration on adult and child flu
- Commissioning proposal near finalisation with Health Visiting to deliver nasal flu to 2 and 3 year olds from 5 children's centre settings across City and Hackney in Nov / Dec 2020 (capacity for up to 2400 immunisations to be delivered); further childhood immunisations training to be explored
- Woodberry Wetlands PCN QI project – CEG template to record call and recall 'refuser' information to inform vaccine hesitancy education

Key risk / issue areas flagged to SOC ….

- Focus on winter flu at the risk of immunisations catch up – parallel approach required
- Risk of increased anxiety of parents to take children to primary care settings in context of second wave – hence use of other settings
- Ongoing risk of communicable diseasee outbreaks (ie. Measles), due to low uptake of immunisations in key areas

Restoring and improving care after the first COVID peak

Children, Young People and Families : *Support for children with disabilities or additional needs*

Key strategic activities underway / planned / needed to contribute towards this area

- An initial joint funding protocol is being piloted between LBH & CCG to ensure a process is in place to identify the relevant contribution that each agency is responsible for funding in relation to high-cost packages, and has been tested on some cases. A similar protocol for City of London is in development. Education funding requests for 18-25 year olds are also being reviewed via the adults joint funding process
- Continued work to raise awareness of Care, Education and Treatment Reviews (CETRs) across agencies and embed processes associated with the Dynamic Support Register (for CYP with autism and / or learning disabilities at risk of inpatient admission). Includes close monitoring of cohort through a fortnightly MDT between CAMHS, social care and education
- Continued close multi agency review of vulnerable cohorts and service capacity e.g. for children looked after and with continuing care
- Funding approved in principle for an intensive support pathway that will provide behavioural support and multi-agency input to CYP and their families within the CETR cohort that are at risk of inpatient admission or placement breakdown, or requiring support to return to a community setting following an inpatient admission
- Joint working with other NEL CCGs to commission a strengthened end of life and hospice at home service offer from Richard House Hospice and Haven House Hospice utilising NHSE's CCG matched funding provision (funding paused currently by NHSE)
- Ongoing infection control support to special schools and on SEND school travel

Key risk / issue areas flagged to SOC ….

- Impact of increased numbers of EHCP assessment requests on all services

Restoring and improving care after the first COVID peak

Children, Young People and Families : *Maternity - Support to expecting women and mothers in the context of the pandemic*

Key strategic activities underway / planned / needed to contribute towards this area

Service redesign in a COVID context

- Continue COVID (and general) safe delivery of maternity services
- Reviewing virtual pathways and visiting protocols as appropriate, aiming to increase face-to-face contact where possible
- Progressing digital workstream to implement an integrated electronic records system, in line with the recent CQC recommendation
- Proposal drafted to work on improving patient experience and inequalities of outcomes
- Homerton Hospital exploring representation from BAME women with lived experience to identify areas of key importance for women from different communities and explore the best methods of communicating with women within those communities
- Continue health visiting rapid response support for new mothers who require a same day, face-to-face appointment and facilitate closer working with early help services in the context of wider identified e.g. increasing levels of domestic abuse

Delivering on our LTP and integrated care ambitions

- Aiming to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025 through implementing saving babies lives care bundle and continuity of carer model
- Aiming to achieve level two Baby Friendly Initiative for maternity and Health Visiting
- On target to provide choice and personalisation of maternity care and improving safety
- Increased perinatal mental heath offer
    - Expansion of existing perinatal service to increase access rates and service offer in line with LTP ambitions
    - Bid submitted for NHS England funding to implement Maternity Mental Health Teams (MMHTs) from April 2021; awaiting outcome. MMHTs will provide specialist input for trauma relating to the perinatal period

Key risk / issue areas flagged to SOC ….

- Homerton anticipating high number of deliveries in November 2020
- Some areas of work, such as carbon monoxide screening, suspending due to COVID
- Levels of face-to-face contact during ante and postnatal care are in line with national guidance but remain below pre-COVID levels

Restoring and improving care after the first COVID peak

Neighbourhoods and Communities: *CYP Neighbourhoods - Support to families during the pandemic*

Key strategic activities underway / planned / needed to contribute towards this area

- Work with stakeholders across health, education and social care to develop pilots that test enhanced neighbourhood working for children, young people and families with a focus on early intervention to prevent the need for statutory and specialist care and interventions in a number of key areas
    - **Ages 0-5:** working to strengthen multi-agency working by building on the strong Multi-Agency Team (MAT) meetings, GP Link meetings and existing universal early years offer for this age group
    - **Ages 6-19:** exploring how to build on the existing Children and Young People's Partnership Panel to develop stronger multi-disciplinary working. Areas of focus include strengthening relationships between primary care, schools and families, and enabling a **'think family' approach** for vulnerable families to strengthen pathways between services and multi-agency team meetings and improve links between services supporting vulnerable adults, children and families (in cases where those adults have dependent children aged 18 or under). Additionally, we drawing learning from the 0-19 Early Help pilot underway in Hackney Marshes and will explore how neighbourhoods working can be enhanced through accepting referrals from GPs and Schools
- We are scoping what opportunities a **social prescribing** programme for Children, Young People and Families may be able to offer within City and Hackney and how this could strengthen the links between Primary Care, Statutory and Voluntary Community Sector CYPMF providers as well as support preventative health outcomes
- Working with the CAMHS Alliance and drawing learning from the Primary Care Liaison Pilot, we are in the early stages of exploring how support for CYPMF may be able to brought closer into communities through blended multi-agency working

Restoring and improving care after the first COVID peak

Neighbourhoods and Communities: ***Ensuring that all primary and community and voluntary services in Neighbourhoods are accessible and safe in the context of the coronavirus, and that we have suitable plans in place to reduce the impact of seasonal flu and a potential second wave***

Key strategic activities underway / planned / needed to contribute towards this area

a. **The City and Hackney winter planning and assurance process captures a range of actions underway** to support winter and COVID preparedness. Flu is a large element of this, and there is a separate, comprehensive flu plan in place
b. **Each organisation has developed its own winter and COVID preparedness plans.** This includes escalation plans to respond to potential increased is demand from covid, and continued delivery of infection prevention control arrangements.
c. **The Adult Social Care Winter Plan includes** actions to ensure continued, safe delivery of care homes, domiciliary care and community services through winter and the continuing pandemic. Additional funds have been committed to providers to support infection control
d. **Humanitarian assistance and voluntary sector response and support put in place in spring is continuing**
e. **Partners are working together to implement large scale covid vaccination for all eligible residents**. Vaccinations will be given to most of our population at mass vaccination sites – these are being organised by the NEL group, whilst primary care will be responsible for vaccinating more vulnerable populations at identified locations, and NHs providers will be responsible for vaccinating workforce.

Any key risks / issues for SOC members to be aware of….

- Impact on staff as a result of the pressure of winter / COVID response – need to focus on supporting staff wellbeing.
- Need for continued mutual-aid approach across services to support each other with the response over winter.

Restoring and improving care after the first COVID peak

Neighbourhoods and Communities: ***Implementing new models of care across different services and organisations to promote more personalised, joined-up, holistic and preventative care delivered in Neighbourhoods***

<u>Development of 21/22 Neighbourhood plans underway</u> (discussed with ICB in December / final plans to ICB in January)

1). Development of new models of proactive care:

- **Children and young people:** See slide 16 - focus on 0-5s and 6-19s (children absent from school / missed appointments)
- **Working age adults:** See slide 19 - Rollout of Neighbourhood blended teams for Mental Health *(Q4 2020/21 and by Q1 2021/22)* and new pathways developed for people with long-term conditions (from Q1 21/22).
- **Older people:** Currently developing anticipatory care model with PCNs with a view to evolving MDT working to support this by Q1 21/22 and rolling out the approach during 21/22

2). New Neighbourhood based service models (will form part of multi-agency teams):

- Adult community nursing (Q4 20/21 – Q1 21/22); Adult social care (Q4 20/21); Adult community therapies (SPOA by Q1 21/22 and new model Q2 21/22); LBH Neighbourhoods Home Care Pilot (Q1-Q2 21/22); Community navigation – currently developing model and rollout during 21/22 subject to transformation funding in 21/22.

3). Coaching and development of Neighbourhood blended teams:

- Initial small pilot OD to support MDT working planned (commission Q4 20/21) carry out during 21/22 and then wider OD plans to be scoped by Provider Alliance Partners

4). Development of resident engagement and voluntary sector partnership approach:

- Community influencers pilot and rollout (Q4 20/21), continued development of Neighbourhood Conversations (21/22) and Well St Common Partnership (to Q2 21/22).

Key risk / issue areas flagged to SOC ….

a. Impact of Winter / COVID second wave on delivery of this transformation across City and Hackney.
b. Some of this activity is funding dependent going into next year e.g. Provider Alliance Transformation / Neighbourhoods.
c. Need to continue to enhance engagement with all system partners - PCNs, wider council & voluntary sector services.

Restoring and improving care after the first COVID peak

Neighbourhoods and Communities: *Addressing a wider range of people's mental health and wellbeing needs at home, within primary care and through culturally appropriate local communities resources*

Key strategic activities underway / planned / needed to contribute towards this area

1). Supporting people with SMI and PD in the Community (also covered in priority 2 – implementing new care models):

- MH Neighbourhoods Transformation **i**s being pioneered in two PCNs: Hackney Marshes & Clissold Park. Blended mental health teams (ELFT, VSO, pharmacy) are in place and VSOs have established links to BAME communities. The pioneer sites support severe and enduring mental health. 2-3 more pilots will be added in the new year.
- We are pioneering the use of a digital platform for SMI, which will enable patients to access recovery plans, psychological and wellbeing apps, personal health budgets (go live date end October 2020).
- The has been additional investment (c£70K) in African and Caribbean heritage health outreach work through the SWIM project and the Open Minds Network (c£100K). Personal Health budget target for 2020-21 is double (400). PHBs are still available for smart phones for people with SMI to bridge the digital divide.

2). Expansion of IAPT

- **IAPT** is receiving an additional c£900K per annum in investment to expand the access rate.
- Homerton's Talk Changes service is fully online and will be expanding its offer in trauma and long term conditions and focusing on the impact on Covid in terms of health anxiety, bereavement and trauma. All staff planned to be in post by October 2020. Mind, has expanded the IAPT service for African and Caribbean heritage communities and Derman has expanded IAPT services for the Turkish speaking community. Expansion currently up and running.
- Both have extensive online services. Bikur Cholim's case for expansion for the Orthodox Jewish community is being reviewed.

Key risk / issue areas flagged to SOC ….

1. Risk of IAPT not receiving sufficient referrals. Referral numbers are down because there are less GP referrals.
2. The demand for therapy for more complex problems (beyond the scope of IAPT) is rising and there is growing waiting list.

Restoring and improving care after the first COVID peak

Neighbourhoods and Communities*: Developing a range of urgent and rapid response services which allow residents to be treated closer to home, and to reduce time spent in hospital*

Key strategic activities underway / planned / needed to contribute towards this area

a. **The new GP out of hours (GPOOH) home visiting service went live on 1st November** – ensuring that all primary care out of hours and rapid response services are in place for winter.

b. **There is a broad programme of work underway to deliver the 'Think 111 First' agenda in NEL.** This is being overseen by the NEL UEC Steering Group, and aims to do the following:
   - Increase the capacity and capability of 111 so that they can receive more calls, treat more calls and be able to better direct (and book) patients into a wider range of acute, community and primary care services
   - Reduce the number of people being sent by 111/999 into acute services through improved clinical validation, improved pathways into primary care and community services and improved uptake of ACPs
   - Develop pathways from 111 into acute services that reduce the likelihood of crowding in ED – these include direct booking into appointments in ED and direct referrals/pathways into other services such as SDEC or hot clinics. Direct booking from 111 into Homerton ED went live on 26th November.

c. A national comms campaign is starting ON 1ST December to increase use of 111, this will be supplemented by regional and local comms.

❖ **Through all of these actions there is an expectation that people use 111 as an alternative to walking to ED**

Key risk / issue areas flagged to SOC ….
- The NEL comms campaign is yet to be launched
- There is a risk that we do not reduce the number of walk ins to EDs as these people do not use 111

Restoring and improving care after the first COVID peak

Restoration of elective activity and reducing the numbers of people waiting for care as a result of the coronavirus pandemic including proactively focusing targeted interventions on those residents with long term conditions who are most at risk

The following NHS 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).

Key strategic activities underway / planned / needed to contribute towards this area
Community support for people with long term conditions (LTC):

- Standing back up the GP Confed LTC primary care contract with detailed advice on prioritisation and adjustments due to Covid-19. Maintaining the focus on proactive care for people with COPD and Asthma, diabetes, hypertension, heart failure, Learning Disabilities and SMI incl. flu vaccination. In wave 2 of Covid-19, we have reduced the targets required in the LTC contract and asked practices to focus on those most at risk- i.e. with multiple LTCs.
- Inequalities work on cohorts at high risk of COVID19: Mapping LTC contract indicators by characteristics including ethnicity, BMI and deprivation. Data to be presented to PCNs to inform targeted approach to inequalities. Also as above re: LTC contract.
- Communication piece in Hackney Today asking patients with LTCs to optimise their health before the winter season by attending review appointments.
- Development of remote monitoring and potential to increase capacity in specialist teams embedded with primary care (diabetes, heart failure, respiratory) and / or primary care. HV model for simple diagnostics developed and on the shelf ready to be implemented
- Medicines management support – discussions underway to support interventions with high risk patients – diabetes, hypertension

Restoration of Elective care:

- **Acute alliance** are coordinating the return of elective operations with the hub sites for high volume low acuity specialities – general surgery, gynaecology, orthopaedics, ENT, ophthalmology, urology. GP leads identified for clinical summits in Oct/Nov. Day case/endoscopy restarted at Homerton and appropriate patients treated in independent sector where possible.
- **Outpatients**: Ongoing work and communications to strengthen and add to existing Advice and Guidance (A&G) models ie New models of virtual support that will enhance the access to specialist clinical support for GPs beyond A&G to improve and widen the community care offer. Patient Initiated Follow-Up (PIFU) and redesign opportunities: alternative approaches to hospital services / enhanced specialist outreach to support community / primary care and maximise LTC management in the community e.g. 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.

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: ***Better integrating the health and care offer to residents in care homes and residential settings as a local system, including more proactive support by primary care, and better support for testing and infection prevention and control***

Key strategic activities underway / planned / needed to contribute towards this area

- The **PCN DES** officially started the 1 October; however GPs have been doing weekly MDTs and ward rounds under previous contracts or new COVID arrangements. The GP and care home staff compose the core team and PCN pharmacists will also conduct weekly rounds with residents identified by the GP. A wider MDT should take place monthly with additional community service staff as required.
- Mental health, learning disability, community nursing and therapy leads have been identified and the Homerton are now exploring how geriatricians can provide support to care homes (as required).
- Discussions continue with NEL CCGs to develop a joint specification and rate for an EHCH Supplementary Care Homes service which covers best practice within the framework that is not covered by the DES. A business case is being developed to address the financial pressures across WEL/BHR systems. the principle is to try to level up services rather than level down as C&H CCG invests more in current contracts.
- **Flu immunisation**: Many GP clinical leads began flu vaccinations for residents in September. The GP Confederation and Community pharmacists are leading a wider roll-out of vaccinations, for residents & staff within all residential settings.
- **Covid-19 Testing:** In August 2020 the CCG commissioned the GP Confederation to provide training, advice, and testing support via a registered nurse and team of HCAs. The initial focus was on CQC registered settings; however, an additional 30 supported living sites are being supported as they have now been given access to the national testing portal. The team reports into the City and Hackney Care Homes Testing Working Group.
- Beis Pinchos and Acorn Lodge have been chosen to participate in the national pilot to roll out Lateral Flow Tests for care homes. this will increase staff and resident testing and allow testing for visitors.

Key risk / issue areas flagged to SOC ….

Visiting in care homes and other residential setting is a critical issue as we need to balance the mental health and wellbeing of residents and their relatives while reducing the risk of COVID. Public Health are leading on the roll out of Lateral Flow tests and visitors guidance to support providers.

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: ***Ensuring that we proactively monitor and address the additional needs of particularly vulnerable patients and patients most likely to be adversely affected because of inequalities resulting from the pandemic*** **:**

- ***Supporting people with Dementia;***
- ***Supporting Vulnerable and LD patients***

Key strategic activities underway / planned / needed to contribute towards this area

Vulnerable patients work:

- Risk tool in development for practices and services to understand the impact of covid 19 on vulnerable groups and target their activities accordingly
- Likely focus for LTC on the most high risk groups of 3+ LTCs to ensure patients are well supported re their risk and if they choose to 'shield' that their needs are met
- Currently no formal shielding programme though we are working in coordination with LBH and with CoL to ensure that vulnerable communities have access to food, advice, welfare support and that we have safeguards in place to limit the impact on the most vulnerable clinically, socially and economically. Our ultimate aim is to integrate this function services in PCN/Neighbourhood and make use of the data and learning from first wave to focus our efforts working closely with the CVS.
- Remote monitoring protocol for hypertension and purchase of BP monitors for practices to distribute
- Heart Failure patients – new service offering iv diuretics in home environment, avoiding hospital admission (from 09/20)
- Aim to expand remote monitoring to clients with LTCs via additional equipment and staffing in specialist teams
- support primary care management of diabetes and respiratory conditions via specialist pharmacist support – virtual clinics, lifestyle advice and medications adherence

LD patients:

- Programme of work in primary care to support clinicians in offering annual health checks to clients with LD – This work is ongoing including advice on delivering virtually where appropriate
- LBH welfare checks on all Integrated Learning Disabilities Service users were carried out
- Flu vaccination programme of staff and residents -in Care Homes – supported by community pharmacists
- Winter handbook has been distributed to providers highlighting specific needs of LD population and need for early intervention/prevention this includes a winter ready checklist and links to advice on infection control and flu imms
- Digital inclusion offer is being developed to support remote and virtual access to activities & connecting with others

Key risk / issue areas flagged to SOC ….

- Capacity in GP practices to deliver this work, given Covid constraints.
- Availability of flu immunisation stocks

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: *Developing new pathways and services for residents with long term rehabilitation needs after COVID-19*

Key strategic activities underway / planned / needed to contribute towards this area

- Multi- stakeholder steering group overseeing this work - Ongoing
- Audits undertaken in all care settings to estimate demand. Key finding indicate the highest level of need to be in fatigue management, breathlessness and psychological support
- A system wide approach with a personalised assessment and care plan is being adopted, in line with NHSE/I guidance. The most recent guidance includes a requirement for an ICS level specialist hub for patients requiring specialist diagnostics and advice
- Primary care triage using functional impact assessment will identify patients who require more than a self-management approach.
- Single point of review clinic for those with specific needs will direct patients to most appropriate pathway including group education and support or more bespoke services GP education sessions on assessment and triage of this patient group has started
- ICP breathlessness pathway signed off across partners; GP education session provided
- Business case has been submitted to FPC and mobilisation resources have been agreed in the first instance
- Strategically, we need to ensure that existing rehabilitation services are not disadvantaged and additional capacity is built in as BAU
- Communication and education plan for stakeholders will be required (management of long Covid) We have carried out a number of patient engagement activities and have 2 residents with long Covid helping us design services
- A NEL wide group is looking at consistency of service across the area. A NEL service specification has been agreed with local content embedded. There is a plan for an iterative approach as service requirements become clearer.

Key risk / issue areas flagged to SOC ….

- Capacity of existing services e.g. pulmonary rehab already very stretched pre Covid
- New services need resourcing – finance and staff (risk around ability to recruit)
- Demand estimates based on first wave – evidence is still emerging.

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: ***Ensuring that the 'in for good' approach taken to support homeless people and rough sleepers is maintained and built upon.***

Key strategic activities underway / planned / needed to contribute towards this area

A local partnership group of key stakeholders, including health, housing, social care and public health, are meeting monthly to coordinate the below strategic activities:

- Oversee the increase in local accommodation provision for rough sleepers during COVID-19
- Work with the Greater London Authority to decant rough sleepers from GLA Accommodation to locally commissioned accommodation
- Lead on the development of sustainable housing solutions for rough sleepers in the long term to meet the 'In For Good' Agenda
- Review rough sleeper CRISP health assessment data and use this to inform service development
- Lead the implementation of a robust protocol for residents who present with COVID-19 symptoms, including testing, isolation accommodation and staff awareness
- Develop a homeless pathway discharge team based at the Homerton Hospital to ensure patients have access to Out-of-Hospital support and are only using acute services if this is the best thing for them.
- Work with North East London to improve services and accommodation for rough sleepers across NEL- taking advantage of scale where beneficial.
- Work with the Greater London Authority and Healthy London Partnership to plan sustainable housing solutions and improvements in health/care interventions for rough sleepers- that are responsive to the impact of COVID-19.
- Partners are developing a bid for the DHSC Shared Outcomes Fund (due 4 Dec.) to support out of hospital care models.

Key risk / issue areas flagged to SOC ….

- Financial sustainability questions about enhanced service provision, including accommodation and other care services
- Access to testing, including asymptomatic testing, for rough sleepers and service staff
- Risk of winter to rough sleepers and capacity for developing services with increasing COVID cases.
- Increasing flow of rough sleepers to the street
- Implications for support of residents with No Recourse to Public Fund

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: *Building on effective discharge processes while maintaining consistent and effective discharge and continuity of care for residents*

Key strategic activities underway / planned / needed to contribute towards this area

- **Discharge:** Partners launched a new Discharge Single Point of Access (DSPA) at the Homerton on the 26 October which includes staff from the Integrated Independence Team (IIT), the Integrated Discharge Service (IDS), LBH Brokerage and Age UK East London. The team will embed the discharge to assess (D2A), home first model which is required in the revised Discharge Policy published the 21 August. Patients who do not meet the criteria to reside in hospital will be identified at morning ward rounds and the DSPA team will have a morning an afternoon meeting to enable same day discharge.
- The CCG Finance and Performance committee approved the business case for a homeless hospital discharge team and partners have had a first meeting to discuss mobilisation plans. The intention is to have a team in place by March. The recommendation for this team is based on the findings of an independent needs assessment, carried out by the charity Pathway between December 2019 and March 2020. Some existing system resources will also be aligned to form part of the team.
- **CHC:** Following the reintroduction of continuing healthcare assessment (CHC) assessments from the 1 September there are now two streams of activity that partners are managing:
  - CHC assessments for individuals discharged between 19 March and 31 August 2020 (Deferred Assessments) –A desktop pre-screening exercise has started to determine whether individuals do not require a checklist, require a checklist or go straight to a full CHC assessment. The CCG must complete a Sitrep every two weeks to report progress to NHSE.
  - Routine NHS CHC referrals, starting from 1 September 2020 – Care Act and CHC assessments must be completed within 6 weeks.

Key risk / issue areas flagged to SOC ….

- There are some challenges on discharge options for people with no recourse to public funds, the homeless and hoarders. We are seeking clarity on the use of the 6- weeks Discharge fund for block funding of accommodations and additional initiatives that build capacity.
- If Care Act or Continuing Healthcare assessments are not completed by the end of the 6-week period of centrally funded care, funding will covered 50-50 by the LA and CCG.
- We have low provision of local care homes and the domiciliary care market also has capacity challenges. A separate exercise is underway by LBH to re-procure domiciliary care.

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: *Ensuring that we improve end-of-life care within our health care system*

Key strategic activities underway / planned / needed to contribute towards this area

Marie Curie End of Life Rapid Response Service

- Since December 2019 we have been running a pilot End of Life Rapid Response overnight (10pm-8am) service. Provided by Marie Curie, this delivers a rapid response nursing and healthcare assistant service to end of life patients in their usual place of residence. Receiving referrals from district nursing, community palliative care, LAS and GPs, and responding directly to call-outs from patient carers, the team (based at St Joseph's Hospice) visits patients within 2 hours of a call. The service reduces anxiety and stress for patients and families, increases collaboration amongst providers, and supports people in their preferred place of care, as well as reducing the use of ambulance conveyances and hospital admissions.
- Activity data from the service to date demonstrates significant benefits from a quality and from a financial perspective. In the context of the pandemic, the service has proved to be an important pillar of our community End of Life response.

COVID 19 & Winter Planning

- The End of Life Care Planning Group has been meeting regularly since the beginning of the pandemic to ensure a coordinated response across end of life services in City & Hackney. The group is focused on ensuring the system is well prepared to cope with the pressures of winter and a second wave of COVID-19 infections. The current priority is on producing updated guidance for primary care on a range of EoL issues including Advance Care Planning, Medicines Management, and procedures around verification and certification of death. This work is closely linked with the NEL End of Life Planning Group chaired by David Maher.

Restoring and improving care after the first COVID peak

Rehabilitation and Independence: *Ensuring that we improve end-of-life care within our health care system*

Key strategic activities underway / planned / needed to contribute towards this area

Care Planning Update

- As of May 2020 we currently have 4401 of our most vulnerable patients with an urgent care plan on CMC and there has been a significant increase in uptake of views of these care plans across the urgent care system, particularly LAS, who during the first wave of Covid-19 viewed nearly all C&H CMC plans.
- In preparation for a second wave coupled with winter, all CMC care plans were updated by the 30th September, except those care plans which have been created in the last 6 months.
- We are scoping the roll out of MyCMC – the patient led care planning functionality on the CMC tool

Bereavement

- The St Joseph's Hospice Bereavement service has been expanded during the pandemic to provide services to children and young people who have suffered a bereavement, in addition to the adult bereavement service they already provide to all residents of City & Hackney. Additionally, the StJH team has provided some specific training to local IAPT providers on traumatic bereavement. Information leaflets for the bereaved have been produced by the NEL team, and signposting to bereavement services has been included as part of the Hackney volunteer hub, while consideration of referral to appropriate (traumatic bereavement) services following a suicide has been included in the suicide response framework.

Key risk / issue areas flagged to SOC ….

- The pilot End of Life Rapid Response pilot is due to finish on 31 March 2021. The pilot is shared with Newham CCG, and the future of the current arrangements depend on their continued partnership. If Newham CCG opted not to extend funding, or to deliver a different model this would pose a significant risk to our the C+H service.

Restoring and improving care after the first COVID peak

Digital and IT Enabler – Improving integration of care and digital inclusion

1. **Care pathways integration** – *digitally joining up the care providers and provider systems supporting integrated care pathways, Neighbourhoods, end of life pathways*
2. **Telehealth, Remote Monitoring and Assistive Technology** – *supporting patients post COVID; care closer to the patient's home*
3. **Websites and apps** – *instant and easy access to online service information and resources for patients and for health and care professionals*
4. **Population Health** – *using the information we have to direct resources and action where it is most needed and maximise our impact*
5. ***Linking to the*** **digital inclusion and digital first programmes of work**

The NHS has introduced a range of measures to ensure patients are safe at all times, including Covid-secure wards and phone and digital appointments

Key strategic activities underway / planned / needed to contribute towards this area

- Key projects already underway include east London Patient Record (data sharing across health and social care) , virtual (video) patient consultations (outpatient and community services); Find Support Services for local residents; Discovery (population health); embedding Coordinate My Care across the system (shared care planning for those at end of life/vulnerable and at risk of unplanned admissions)
- New programme of work drafted, to include: telehealth/telecare capabilities, extending eLPR to further enhance collaborative working, digital resource platforms to widely share best practice and support communities of practice
- Linking with the London Borough of Hackney led programme of work for Digital Inclusion to maximise opportunities across the local population in the adoption of technology, noting the shift to virtual first in health
- Working collaboratively with the wider ELHCP programmes of work including integrated urgent and emergency care, digital first for primary care and care homes, and the personal health record (PHR - eventually linking in with care planning and remote monitoring)
- IT Enabler working collaboratively with the One London programme on eLPR developments to support integrated care – wider data sharing and image sharing

Key risk / issue areas flagged to SOC ….

- IT Enabler funding is capped; there is a reserve of ~£1.3m for new projects
- The level of digital transformation to be achieved is largely dependent on identifying large scale and high impact areas of transformation opportunities in the overall integrated delivery plan

Primary Care – City and Hackney Priorities

	QUALITY	NEW MODELS	WORKFORCE
6 MONTHS	• Practices continue to work with their PPG groups particularly when developing and evaluating new services • Address unwarranted variation of core funding between GMS, PMS & APM	• Online new patient registration in every practice • Maintain a hot hub offer for practices that can't appropriately zone their building • Maintain a hot hub offer that can easily be escalated in response of possible future surges of COVID-19 activity • One QI expert per PCN • Plan for adoption of QI philosophy and methodologies addressing practice, PCN/Neighbourhood and wider system challenges as required • Further develop borough level GP Federations to support practice and PCN development, resilience; workforce recruitment, retention and CPD, COVID-19 response; delivery of enhanced service • Agree design for new build for Spring Hill practice and renovation of Lower Clapton group practice	• Support all staff through and beyond the impact of COVID-19 pandemic/endemic • Develop training schemes for practice manager and administration staff that incorporate the need to work in different ways with new skill sets • Develop volunteers programmes at practice and PCN/Neighbourhood levels as part of wider system engagement and collaboration
12 MONTHS	• Enhanced influenza campaign • Contract, appropriately scaled to meet need with every care home to include, at least: primary care and community nursing • Show improvement in patient experience metrics, focused on satisfaction with accessing primary care • Health checks for people with a learning disability and people with a severe mental illness	• Maximise use of on-line consultation in every practice • Where appropriate, maximise use of telephone and video consultations • 20% uptake of the NHS app from local baseline • All practices to have digitised and embedded patient's paper records into EMIS	• Pharmacist in every practice • Optimal use of the PCN DES ARRS budget, allowing for practice/PCN preferences and maximal use of HLP flexibilities regarding spend
18 MONTHS	• At practice and PCN level show improvement where ratio of WTE GP/Nurse/Other PT facing staff : 1000 patients is below the London average • Show improvement in patient experience metrics, to include satisfaction with quality of GP practice and consultation. % of LTC patients feeling supported to self-manage conditions. % rating of overall of GP surgery as 'very good' or 'fairly good' • Embed into practice's BAU systems peer to peer review of potential non-urgent referrals and the undertaking of regular case-based discussion • COVID-19 testing, tracking, and tracing - primary care as part of a response coordinated at Borough level • Care planning with patients, held by patients and reviewed regularly by partners across health and care systems 24/7	• Enhance advice + guidance 1ry/2ry communication • Enhanced quality of communication 1ry/2ry interface • Undertake, face-to-face consultations compatible with best practice in infection prevention and control and staff risk assessment, including for essential routine care • Support reduction in digital poverty and work locally to improve IT literacy • Develop home monitoring for patients with possible COVID-19 and for patient's essential routine long-term condition management • PCN/Neighbourhood based MDT meetings for patients whose care needs to be supported by multi-professional groups working together • Practice based MDT meetings in every practice where review does not require discussion at PCN neighbourhood/level • Workflow optimisation in every practice • Scaled up offer of support to primary care from Clinical Effectiveness Group • Mobilise opportunities that flow from locally sensitive implementation of the new Direct Enhanced services element of the nationally agreed General Medical Services contract with Primary Care • Financial modelling to identify additional capital investment in out of hospital care • Develop optimum use and value from newly established IT software and hardware that is embedded into BAU clinical practice and CSU IT support and asset registration • Support estate review and planning to reflect new ways of working and support COVID-19 risk assessment for staff and patient and embedding necessary measures to address Infection prevention and control	• Social prescribing link worker in every practice • physiotherapist aligned to every practice to provide a collaborative physio-first response for patients • Develop training schemes for practice nurses (undergraduate and specialist post graduate training schemes) that incorporate the need to work in different ways with new skill sets • Establish baseline, then work to improve staff satisfaction and morale

Winter Preparedness 2020/21

Our 20/21 winter planning

Introduction

The ongoing pandemic, the potential for a second peak of CoVID-19 and the risk of a concurrent flu outbreak mean that this winter could bring unprecedented challenges. Winter planning this year is particularly important.

Historically winter planning has been a discrete exercise involving mainly urgent and emergency care (UEC) services/partners, based predominately on a template and approach set by NHSE. This year, we are taking a whole system approach to minimising the risks from the coming winter.

We have recently updated the integrated action plan that the C+H SOCG oversees, and winter is one of the specific lenses through which we developed this plan.

The Winter Planning Process

Members of the unplanned care workstream did a review of winter planning over the past few years, and summarised the key elements of what should be kept and what should be done differently:

Things we have kept

- System plan – includes input from a wide range of system partners
- Focuses on admission avoidance, discharge and community services as well as acute capacity

Things we have changed

- Considers winter across all of our programmes of work – rather than a standalone exercise undertaken with UEC partners.
- Historically has been undertaken in September / October – this year we have started much earlier
- The plan has been driven by our local system needs, rather than criteria set by NHSE.
- We have considered wider community based support – beyond just admission avoidance or discharge
- There is a much stronger focus on flu to really tackle longstanding challenges in this area.

Winter Preparedness 2020/21

The Plan

The winter 'plan; is not a single detailed plan for winter, rather, it is an assurance document that identifies the key risks and outlines all of the areas that we need to address for winter and described where these are being addressed and identifies any challenges. Some of the actions sit within single organisations, some are a responsibility of partners within the City and Hackney system and some are NEL or even London-wide. A detailed view of the activities within the winter plan and their rag ratings can be found on the annexed pages

One of the areas where the actions sit outside the City and Hackney system is ensuring that the Flu vaccine is available to GP Practices and pharmacies.

Flu vaccine

The Covid-19 pandemic has added an additional challenge for the NHS as we head into winter. NHSE has expanded access to free flu vaccination on NHSE to over 50s, pregnant, has a long-term health condition, or is in a shielding household.

NEL : We have already seen huge early demand for the flu vaccination and a lot of people have already been vaccinated. However, some people have not been able to get vaccinated straight away as some GP practices and pharmacies have used their first deliveries of flu vaccine, due to the level of early demand. More will be delivered - people shouldn't feel they have to rush out and get vaccinated in September or October, as the vaccination programme continues right up until and into the flu season, which doesn't normally start until December. There is enough flu vaccine for everyone who is eligible.

Critical Risks for winter 2020/21:

- Risk that demand on healthcare services exceeds capacity – either through a spike in CoVID infections or other through crisis or deteriorating health from other conditions
- Risk that we cannot discharge patients quickly and safely when they are medically optimised
- Risk that we cannot support our vulnerable residents to stay well through winter
- Risk of increased demand on services and mortality from a flu outbreak

Winter Preparedness 2020/21

Borough specific plans

Summary of our preparedness for winter - Hackney

- Winter plans this year cover second wave COVID and usual winter pressures
- DHSC have required local authorities to put in place their own winter plans, building on
- existing planning and we are on track to provide this information to the DHSC by 31st
- October.
- City and Hackney Public Health Team and our partners, including the NHS, are continuing to address inequalities locally, by involving people with lived experience wherever possible. Implementation issues are considered as part of this winter plan.
- We have completed a short version of an EIA Checklist and Inequalities Matrix, developed by PH for the COVID response.

The plan covers 4 themes:

- Preventing and controlling the spread of infection in care settings
- Collaboration across health and care services
- Supporting people who receive social care, the workforce, and carers
- Supporting the system

Summary of our preparedness for winter – City of LOndon

- Completed the ADASS Local Authority Actions for Winter Planning gap analysis issued through Local Government Association. Actions on gaps identified and being addressed.
- Continuation of access to hotel accommodation to facilitate discharge.
- Additional social work capacity to provide cover at weekends (previously been OT cover).
- Working with our two home care providers (one for rapid response) to ensure contingency plans in place. Also working with them to plan use of infection control funding.
- Continuation of provision of accommodation for rough sleepers at Carter Lane Hostel. Working with partner organisations to support clinical outreach and primary health care for flu vaccinations etc. Establishment of pathways for homeless and rough sleepers to the Neighbourhoods Multidisciplinary Teams (MDT).
- Working with Public Health to promote flu vaccinations across residents and providers
- Have an ongoing store of provisions such as heaters and fleeces for those who may be vulnerable and at risk because of winter cold at home

Winter Preparedness interdependencies

- New hospital discharge policy, ensuring same day discharge and a ‘Home Visit’ model with funding from the NHS for up to 6 weeks post discharge care and assessment.
- Second wave of Infection Control funding, to be distributed to care homes, home care providers, residential settings and homeless and rough sleeping pathway providers.
- Designated setting requirement - Acorn Lodge have become our dedicated setting for care for people discharged from hospital who have a COVID-19 positive status

Winter Preparedness 2020/21

Flu Communications and Engagement Plan: Background and Our Approach

Background

From September 2020 –March 2021, health care organisations across City and Hackney as well as North east London (NEL) are expected to deliver key messages to vulnerable people and patients on how to stay well during the winter months

- Winter pressures messaging will need to respond differently this year as a result of the impact Covid-19 has had. Communications and engagement activity will need to reach new cohorts of patients in relation to the flu vaccination programme, as well as instilling behaviour change across all health populations to reduce pressures on urgent and emergency care services
- Whilst NHS England / Public Health England is expected to deliver a national campaign which will include messaging on flu vaccination, use of NHS 111 service, and messaging on Covid-19, we want to ensure that there is a joined-up approach to managing winter related health messaging across the City and Hackney system partners creating a clear, consistent, and prominent voice

Campaign approach

- **Deploying a single overarching health campaign for North East London/ City and Hackney –** We will need an integrated marketing, communications, and engagement campaign across north east London that will focus on four key phrases (i.e. NHS Is Open For Business, NHS111 First, Public Flu, and Staff Flu – for CCGs and Primary Care only). This campaign will uplift national messaging and ensure creative is localised in City and Hackney to patient cohorts and channels
- **Collaborating with partners –** We need to work collaboratively as partners (e.g. CCGs, trusts, practices, local authorities, Healthwatch, local communities, etc.) to pool knowledge and ensure comprehensive audience reach, message consistency, and campaign recall across C&H
- **Targeting messages led by the data –** We will use local data to help priorities the key patient cohorts and specific geos / communities where there is the highest need
- **Optimising campaign activities using live insight –** We will need to access and track daily / weekly data on key performance metrics to optimise and retarget activity during the campaign

Winter Preparedness 2020/21

'Help Us, Help You' campaign

NHS England's 'Help Us, Help You' campaign has launched. It seeks to address the barriers that can deter patients from accessing the NHS and help the public understand how they safely access the best services for them. The Covid-19 pandemic has presented the NHS with one of its greatest ever challenges. One serious impact is that some people are reluctant to use NHS services, citing concerns about being exposed to the virus and not wanting to be a burden on the NHS. The 'Help Us Help You' campaign reminds the public that the NHS is still here to help and that the NHS has adapted services in order to see them safely.

The campaign focuses on four key areas – cancer, maternity, elective care and mental health – and addresses the barriers which may deter patients from accessing services. Following phases will focus on flu and winter pressures. ***The campaign will feature across local media and plans to reach across our local community groups****.*


18 health

Protect yourself, your loved ones and the NHS this winter by getting your flu jab

Do the right thing

"The flu vaccine protects the individual but also stops flu spreading around the community"

Myth busting: Everything you wanted to know about the flu jab but were afraid to ask

Does the flu vaccine gives you flu?

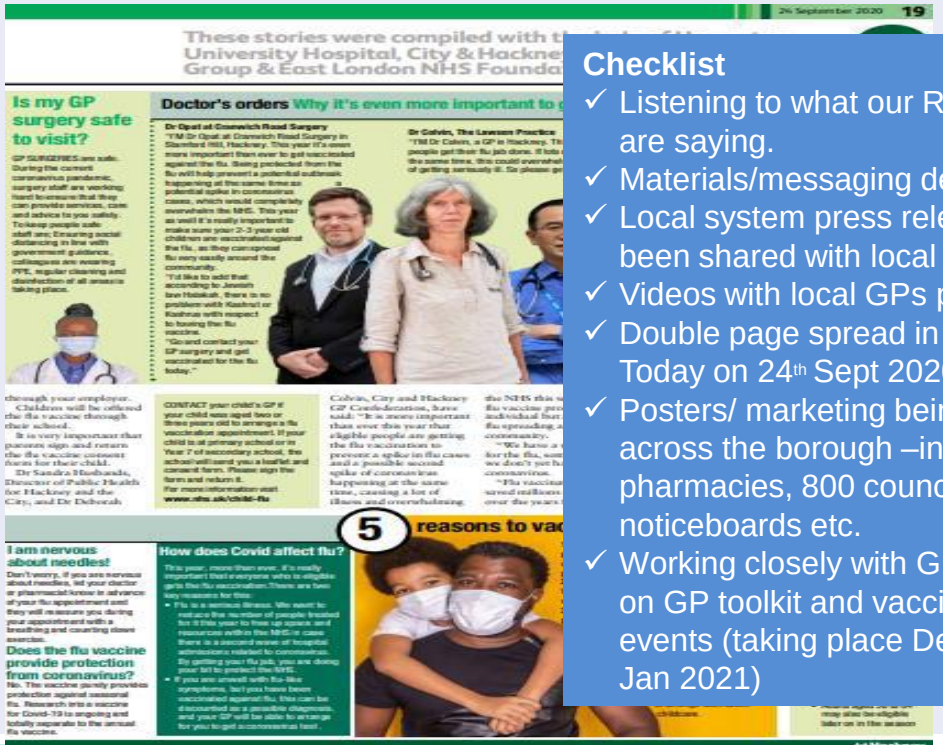
Is it better to get sick with flu than to get a flu vaccine?

I have a healthy lifestyle and don't often get colds or feel ill. What are the benefits for me?

Does a flu vaccination increase your risk of getting coronavirus?

Are the vaccine's ingredients safe?

Is the vaccine halal / kosher?


19

These stories were compiled with the help of University Hospital, City & Hackney Group & East London NHS Foundation

Is my GP surgery safe to visit?

Doctor's orders Why it's even more important to get your flu jab this year

I am nervous about needles!

How does Covid affect flu?

5 reasons to vac

Checklist

- ✓ Listening to what our Residents are saying.
- ✓ Materials/messaging developed.
- ✓ Local system press release has been shared with local media.
- ✓ Videos with local GPs produced
- ✓ Double page spread in Hackney Today on 24th Sept 2020.
- ✓ Posters/ marketing being shared across the borough –in pharmacies, 800 council estate noticeboards etc.
- ✓ Working closely with GP Confed on GP toolkit and vaccination events (taking place Dec 2020/ Jan 2021)

Planning for recovery and second wave: Managing safety, capacity, risk and flow

Tier 2' Covid-19 guidance for London

Cases of Covid-19 are continuing to rise and it has been announced that London will be classed as 'high' risk (or 'tier 2') under the government's new Covid-19 local alert system. This means we all need to do things differently to protect ourselves and our community.

Second wave assumptions

- *Planning assumptions based on national and regional pandemic flu and the behaviour of the virus so far*
- *Infection attack rate - Up to 80% of the total population will become infected (~ 223,643 Hackney population, ~3522 Hackney Council staff) with 66% experiencing symptoms*
- *From studies, it is be anticipated that the hospital admissions would be 23% with an overall fatality rate of 0.5-1%*

Timescales and Key Actions – Public Health

Short term

COVID-19 Social isolation requirements & considerations on Hackney's population /demographic

Local interventions and services from local contact tracing to welfare support, swabbing services in care homes to IPC advice across a range of high risk settings

Medium Term

Planning for delayed medical diagnosis and treatment, unemployment and housing issues, impact on mental health for adults and children, widening health inequalities, impact on the education of those children most in need

Long term

Addressing health inequalities COVID-19 and food poverty with exploration of associated impacts and needs on service provision & corporate priorities

Planning for recovery and second wave: Managing safety, capacity, risk and flow

City and Hackney SOC Second Peak DRAFT Action Plan as of 16th October 2020

Priorities for the next two weeks

Risk area	Action
Care settings	Assure ourselves that robust **IPC and testing arrangements** are in place in all **care settings**
	Overall capacity in care settings to accommodate increase in demand due to COVID
	Progress on local **implementation of designated care settings guidance** (for discharge of COVID positive patients to a designated interim care setting)
Supporting vulnerable people	Assess value in setting **up isolation facilities for high risk vulnerable patients** who may struggle to self isolate at home
	Ensure that **developments in humanitarian aid offer, food security offer, volunteering offer** are communicated with SOC partners and that this infrastructure is stable and vulnerabilities are addressed
	Actions to stabilise homecare capacity
Workforce	**Public transport risk assessment** for at risk staff and mitigations where risks are unacceptable
	Assurance that **risk assessments and changes to working practice for at risk staff** are in place across our local system
Surge and capacity management	Work to ensure that **core primary care capacity** remains stable during winter and second peak, including agreement with commissioners on "*pause*, *prepare to pause* or *maintain*" in relation to LES contract activities, and decisions about hot hubs
	Focus on specific **demand pressure in primary care posed by unwell children**
Other	Assurance that we are **implementing national pandemic guidance/requirements** in specific areas as it is published (e.g. maternity, designated care settings, discharge policy, shielding guidance, etc)

Priorities for the next two months

Risk area	Action
Supporting vulnerable people	If the business case for **isolation facilities is approved, rapidly implement arrangements**
Surge and capacity management	Mental health plans to **bolster the crisis pathway** and **reduce current high inpatient bed occupancy** to allow for predicted loss of staff capacity
	Consider setting up a **system wide sitrep arrangement to monitor workforce** impacts of self isolation and COVID absence on capacity
Workforce	Need to consider how best to mitigate the **long term psychological impact on staff** and link this support to communities and carers and the humanitarian response

Priorities for the next six months

Risk area	Action
Vaccination	Need to have plans in place as a system for **mass vaccination against COVID** when a vaccine is ready, learning from flu and imms campaigns

Planning for recovery and second wave: Managing safety, capacity, risk and flow

City and Hackney SOC Second Peak Action Plan

Actions specific to Hackney

- Primary care to re-establish hot and cold hubs, to address ongoing capacity issues in the Homerton plus structural challenges.
- Starlight ward may again need to be repurposed to be a COVID ward, due to oxygen supply, leaving the Royal London Hospital to provide the children's ward
- Care home planning to ensure testing and contact tracing, further plans to improve
- infection control quality assurance in care homes and wider supported living settings
- Ongoing challenges to adequately manage long term conditions, two week waits for suspected cancer and waiting lists for hospital care
- Substantial mortuary planning at a coronial district level has taken place to ensure adequate local capacity plus additional London wide storage facilities if needed.
- Standard operating procedures providing guidance to a range of settings, with
- testandtrace@hackney.gov.uk giving much needed streamlined additional support.
- Local contact tracing activated and providing additional back up to the national system.

Actions specific to The City

- Local Lockdown plan developed to support those identified as Clinically Extremely Vulnerable (CEVs)
- Plan developed in line with the Government's Shielding Framework guidance
- Support programme includes direct contact with CEVs to assess their access to food and essential support for grocery shopping, medication collection and loneliness and wellbeing contacts
- Programme of support developed for those identified as needing support due to need to isolate from the Test and Trace programme
- Adult social services user Support Requirement data regularly reviewed
- Recovery and resilience Group meeting to monitor impact of Co-vid on services, to respond accordingly and to plan for recovery of services

Providing support to our Shielded Patients

○ Ensuring that the health care needs of those shielding are being met - access to primary care, flu immunisations, good infection control practices to ensure hot/cold hubs.
○ Emergency food supplies and housing support for those needing to shield or are isolating.

What differences are we hoping to make and how will we measure this?

Our Public Health approach…

Reduce the number of deaths in care settings due to COVID	Ensure patients discharged from hospital who have a COVID-19 positive status are transferred to the designated care setting designed to CQC infection control standards and not sent to a variety of homes.
Ensure the Homerton hospital has enough capacity to cope with second wave COVID and winter pressures	Implementing the Home First same day discharge model, by developing more capacity including 6 discharge flats, assistive technology, contract for 13 care home beds and discussions with Home Care providers to agree block contracts, to be agreed by the end of October..
Support providers to improve infection control Administering	Administering the second round infection control fund. This will be distributed as outlined in government guidance. 80% to Care homes and home care agencies on a per bed or per user basis, with 20% to other residential settings and single homeless pathway providers. To be used to reduce staff movement, ensure staff self - isolating are paid in full and other local measures providers feel are necessary, for example, paying for cycles rather than using public transport, desk shields and hand sanitizer dispensers.
Supporting people who use Social Care services	From phoning people on our shielded list to providing winter readiness checklists we hope to ensure services are vigilant and able to provide safe service COVID-19 positive status discharges from hospital.
Work collaboratively with partners, to help unblock any issues and support flow of people	We have a variety of forums with providers, as well as Quality Assurance officers working closely with providers to ensure services are maintained. We also have a variety of partnership forums and links to ensure good working relationships, including Housing; Age UK, hospital, mental health, LD and Adult Social Care.
To ensure we can operate 7 days per week 8am-8pm to support the hospital discharge process	As hospitals gets busier, we have set up shadow shift pattern for brokers who, as soon as asked, can step in to provide a 7day a week 8am-8pm service, to ensure effective and timely discharges.
To ensure day centres and services can open safely to support clients	We are supporting more day services to open to support more clients over the winter period, via our Standard Operating Procedures

Improving our access to PPE supply

We are reviewing the risks relating to accessing PPE across the system in City and Hackney and proposing actions to mitigate this

System partners have highlighted various difficulties experienced with regards to PPE during the first wave:

1. *Previous national shortages of PPE and disruption to usual supply routes*
2. *Access to the right types of PPE, and in the right sizes*
3. *Staff having to be re-fit tested for different models of FFP3 marks*
4. *Recall of faulty products due to manufacturing defects (Type IIR masks and 'tiger' disposable goggles)*
5. *Access to gowns, googles and FFP3 masks, in addition to support with fit testing, for non NHS Trust providers*
6. *Anticipating demand and ensuring stock logs reflected physical stock holdings of PPE accurately*
7. *Confusion regarding supply routes, compounded by general shortages*

The following risks for the next six months have been identified:

1. *Greater demand for PPE as a result of winter pressures*
2. *Lack of clarify around the circumstances in which the PPE Portal should be used*
3. *Low PPE Portal registration rate among providers across NEL who are eligible to register*
4. *Access to PPE for providers required to care for patients undergoing aerosol generating procedures.*
5. *FFP3 mask fit testing*

NEL : As we move towards winter, we currently have very good supplies of core PPE. Four-month stockpiles of each PPE supply category will be in place from next month to ensure we continue to be well prepared and are able to manage demand.

These recommendations are currently being discussed at the City and Hackney Strategic operational command (SOC):

1. Provide clarity on the recommended pathways for accessing PPE
2. Increase the PPE Portal registration rate and better understand any barriers to take-up
3. Identify who is responsible for supporting health or social care providers required to care for patients undergoing aerosol generating procedures to source the relevant PPE and access FFP3 mask fit testing
4. Local mutual aid is available when all other escalation routes have been exhausted
5. Establish mechanisms to share intelligence and best practice across system partners
6. Guidance around use of PPE – Primary Care and Social Care providers

Appendix Winter Preparedness:

Topics	Where this is being overseen	Challenges or concerns*	What is being done
Acute services readiness and capacity (Homerton)	Homerton	Homerton has a strong track record of delivering good performance through winter.However, this year presents specific challenges given the context of a recent CoVID peak and potential for a second.	Homerton winter planning process in place to support all elements of acute care, includes: -Workforce planning - Improving flow through ED and the hospital -Delivery of ambulatory care
Acute services readiness and capacity (NEL)	NEL Acute Alliance	Modelling shows that there are likely to be bed capacity pressures. The need to segregate CoVID and non-CoVID work further limits capacity, and how flexible we can use capacity.	The acute alliance winter planning, CoVID preparedness and critical care workstream are delivering the following: -Modelling of bed demand and capacity across NEL -Developing plans to try to mitigate demand and deliver sufficient bed capacity - The Critical Care Hub has taken a NEL-wide approach to planning and delivery of critical care capacity. - Agreeing any pathway of service changes that may need to be enacted in the result of winter pressures or a second CoVID peak
Ensuring there is sufficient mental health capacity and pathways	ELFT	There has been an increase in mental health demand as a result of the response to the pandemic.	ELFT operational teams working to ensure sufficient service capacity within ED hospital liaison team and community based crisis response teams. Work underway across NEL to minimise delays accessing beds (mainly an out of area issue).
Improving Urgent and Emergency Care pathways across North East London	NEL Restoration and Recovery of Urgent and Emergency Care Steering Group	There is a need to reduce demand on acute hospital services – both to reduce pressures on acute trusts and to reduce the risk of large volumes of patients arriving at EDs leading to risk of nosocomial infections.	The NEL UEC group are overseeing all of the work to drive the 'Think 111 First' agenda within NEL. This has the overall aim to support improved pathways from 111 and reduce demand on hospital services. **Key actions include:** -Increasing 111 capacity and capability to hear and treat or effectively navigate patients to the right point in the system- LAS -Maximising use of community based rapid response services –Paradoc and IIT -Maximising pathways into primary care – both core primary care and into Duty Doctor
Primary care readiness		-There are expected to be significant demands on primary care through a combination of supporting people who's health and well being deterioriated in the first peak, 'catching up' with all routine health checks, LTC management and supporting people away from the hospital setting wherever possible.	Primary urgent care: there will be a change in provision of GP out of hours home visiting – the new service will go live on 1st November. Whilst this is not ideal for winter preparedness, we have confidence that the new provider has significant experience and credibility. Core primary care The increase in expected colds and flu which can present like covid may also put a strain on home visiting services. One hot hub and associated doorstep assessment service (DAS) is in place and will continue through winter. We will continue to review this provision,
End of life	End of life Care Board	City and Hackney has lower levels of people dying at home than in England and London.	A range of services and initiatives have been put in place to support people to die in their preferred place – -Continued use of CMC to support end of life care planning. There was a specific ask this year to update all CMC plans by end of Q2. -Primary care end of life service -Urgent end of life care service provided by Marie Curie started in November and has seen increasing levels of activity month on month since then. In and out of hours provision of EOLC medicines by local community pharmacists -We have provided access to end of life medicines to Paradoc
Improving pathways and services for children in winter	CYPMF Leadership group	There is normally seasonal rise in paediatric respiratory and flu-like illnesses in winter. This year it is increasingly important to try to support children and parents within primary care and the community so that they only go to	There is a paediatrics hot line available for primary care clinicians to use to support management of children, this will be publicised. The paediatricians are delivering an education session to primary care colleagues.

*The challenges have been RAG rated according to their likely impact on the system and the level to which we have plans to address them

Appendix Winter Preparedness

Topics	Where this is being overseen	Challenges or concerns*	What is being done
Support for people in the community	City and Hackney SOCG	We need to enhance the support that we provide to people in the community in order to help them stay well and avoid crises.	There are a range of different pieces of work underway to support more vulnerable people in the community :- Review and re-focus on primary care support to people with LTCs (Siobhan Harper) Neighbourhoods teams supporting people with more complex needs who require a multi-agency response through the Neighbourhood MDTs We have been using the Neighbourhoods conversations to identify specific areas of concern within communities and to spread important public health messages We are continuing the humanitarian assistance response that was put in place during CoVID through winter. This means that vulnerable individuals can reach out to the local authority to access support as required. This will include issues that are specific to winter such as cold housing or falling on icy streets
Support for care home residents	City and Hackney SOCG	We need to ensure that care home residents have good access to a range of services to support them to stay well	We will continue to CoVID services that was put in place across all of our nursing and residential care homes – this provides dedicated primary care and community services to each home. We have good primary care services to our nursing homes, and this is being maintained.
Reducing delayed discharges	City and Hackney Integrated Discharge Group	Historically we have had high levels of delayed discharges through winter months. There is an underlying shortfall in care home and domiciliary care capacity in C+H. There has been a recent change to national discharge guidance which may present further risks locally.	The integrated discharge group are overseeing delivery of improved discharge pathways in line with the new national discharge guidance. This includes: -Identified executive system lead for discharge -Embedding a discharge to assess mode -Setting up a discharge hub in Homerton CoLC are linking with the discharge hubs being established in UCLH and Barts. We still need to agree what additional step down capacity and packages will be needed for winter and to identify this resource. The group is also developing an improved service and discharge pathways for homeless people.
Whole system flu plan	City and Hackney Flu group	Risk of flu outbreak, which, if coupled with a second CoVID peak could be catastrophic	We have convened a system flu group that is overseeing a whole system approach to flu:- -Comprehensive and wide-ranging flu comms plan in place -including community focus groups led by LBH -GP confederation leading programme to deliver flu jabs through primary care -Increasing flu vaccinations rates through Frail Home Visiting service C&H community pharmacists supporting flu vaccination of residents and staff in care homes -Team in place to deliver CoVID testing to care homes and supported living will also deliver flu jabs -Plan in place to respond to potential outbreaks, including specific support to care homes. Planned car workstream are also overseeing delivery of health checks and delivery of flu vaccinations to people with learning disabilities and autism.
Readiness for a second CoVID peak	Within each organisation	Very likely risk of a second peak in CoVID infections and associated demand on health and care services. Testing capacity and provision of PPE are likely to be critical issues.	-All partners have undertaken learning from CoVID and have plans in place in readiness for a second peak -Key areas where partners can work together have been identified from the first peak and will be enacted again. These include: PPE, IPC guidelines, clinical guidelines/training on specific areas such as end of life.

*The challenges have been RAG rated according to their likely impact on the system and the level to which we have plans to address them

Appendix Winter Preparedness

Topics	Where this is being overseen	Challenges or concerns*	What is being done
Pharmacy support to the wider system		There are a range of areas where community pharmacists and the CCG medicines management team can support the wide system	-Community pharmacists will continue to provide the minor ailments service, the access to end of life medicines service out of hours and support to care homes. C&H community pharmacists supporting flu vaccination of residents and staff in care homes -The CCG medicines management team will support PCNs in delivery of structured medication reviews, anti-microbial stewardship and other prescribing matters. In and out of hours provision of EOLC medicines by local community pharmacists -The CCG medicines management team have developed further proposals to deliver support to PCNs on management of specific conditions (respiratory and diabetes)
Public communications	At all level from National through to City and Hackney	The public comms challenge this year is more challenging than is previous years as we need to address both of the following resident behaviours: -patients attending ED or other settings inappropriately and putting pressure on services -Patients avoiding accessing healthcare when they need it because of perceptions around CoVID,	There is a national campaign that will launch imminently – this will aim to persuade people to access healthcare services if they are worried about anything, it will also promote 111 as the access point into urgent care services. There will also be associated London and NEL comms that reflect this message. We have developed a City and Hackney winter comms plan that compliments this message but will target specific communities. We will also have significant local communications around flu.
Minimising risk of and managing potential outbreaks of CoVID	City and Hackney Outbreak Control	Very likely risk of a second peak in CoVID infections and associated demand on health and care services.	System outbreak control plan and process in place – being led by public health – this includes -governance structure to oversee key data and delivery of plans -Local outbreak control plan in place -Exercise to test outbreak control plan undertaken -Local contact tracing team in place -SOPs for nursing homes, schools and work places to reduce risk of nosocomial infection -Focused work with orthodox Jewish community

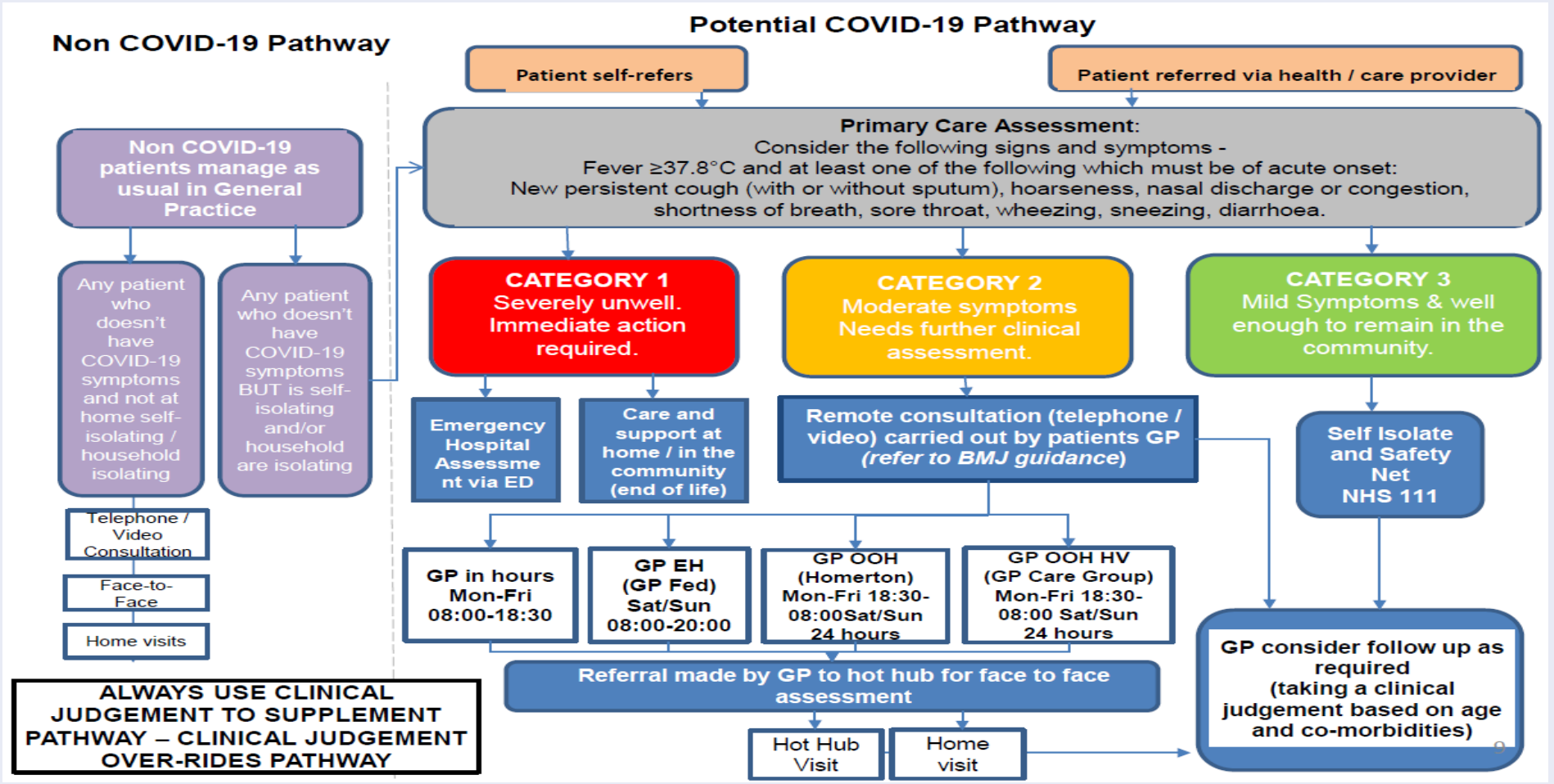
*The challenges have been RAG rated according to their likely impact on the system and the level to which we have plans to address them

Appendix : City and Hackney COVID-19 Out of Hospital Clinical Pathway

COVID-19 NEL Key Line of Enquiry: City and Hackney have responded positively to the 3 points below:

- **KLOE 1 – 111 Clinical Assessment Service (CAS) can safely refer into services over a 24 hour period and are satisfied with the service configurations.**
- **KLOE 2 – Mechanisms in place to refer a known COVID patient for follow up in a 24 hour period and report on outcome of this assessment over the 24 hour period.**
- **KLOE 3 – Process in place for patients to call if worsening in the out of hours period, default to 111 CAS/999.**

Appendix : City and Hackney COVID-19 Out of Hospital Clinical Pathway



Appendix : City and Hackney COVID-19 Out of Hospital Clinical Pathway

KLOE 1 – 111 CAS can safely refer into services over a 24 hour period and are satisfied with the service configurations

Service	System	Provider	Time Frame	Method
GP in hours	EMIS		Mon-Fri 08:00-18:30	GP Connect – direct book into an appointment with PEM sent afterwards to GP
GP EH	EMIS	GP Federation	Sat/Sun 08:00-20:00	Black Pear – direct book into an appointment with PEM sent afterwards to service, GP Copied in (does not work if patient is triaged by another 111 service)
GP OOH	Adastra	Homerton	Mon-Fri 18:30-08:00 Sat/Sun 24 hours	Adastra to Adastra – direct book into an appointment with PEM sent afterwards to service, GP Copied in (does not work if patient is triaged by another 111 service)
GP OOH HV	Adastra	GP Care Group	Mon-Fri 18:30-08:00 Sat/Sun 24 hours	Adastra to Adastra – direct book into an appointment with PEM sent afterwards to service, GP Copied in (does not work if patient is triaged by another 111 service)

Appendix : City and Hackney COVID-19 Out of Hospital Clinical Pathway

KLOE 2 – C&H mechanisms in place to refer a known COVID patient for follow up in a 24 hour period and report on outcome of this assessment over the 24 hour period

Service	From GP in hours to	From GP EH to	From GP OOH (Homerton) to	From GP OOH HV (GP Care Group) to
GP in hours		Via EMIS to practice	OOH call the GP practice to let them know to follow up patient (issue over weekend)	Via EMIS to practice
GP EH	Via EMIS to practice		Via telephone or email	Via EMIS to Federation
GP OOH	Via telephone or email	Via telephone or email		Via telephone or email
GP OOH HV	Via EMIS to GP Care Group	Via EMIS to GP Care Group	Via telephone or email	

KLOE 3 – C&H process in place for patients to call if worsening in the out of hours period, default to 111 CAS/999

Hour	Who
Mon-Fri 18:00-08:00	111/CAS and or 999
Sat/Sun/Bank Holidays	111/CAS and or 999