APPENDICES

City and Hackney Place Based Partnership

Delivering the City and Hackney Partnership Strategy:

2022-24 Integrated Delivery Plan

Introduction

The City and Hackney partnership brings together health and social care organisations who have committed to work together to support improved outcomes and reduce inequalities for our local population. The partnership is overseen by the City and Hackney Health and Care Board and the board have agreed a set of strategic focus areas and the integrated delivery Plan for 2022-24 that describes how we will deliver this strategy.

Context

The Integrated delivery Plan does not describe the totality of the work underway within each of our organisations. We have taken an outcomes led approach, meaning that we have developed actions that will address population health challenges. Many areas of the plan will be driven by, or link to NEL-wide programmes, though we have only captured the City and Hackney element of these.

Content

The pack includes:

- A reminder of the strategic focus areas
- High level view of achievements and risks
- Progress against our **'big ticket items'**.
- We have flagged the most significant risks and issues in red

The progress report against the full delivery plan can be provided on request

Work is underway to develop a partnership performance report that will track delivery of key outcomes and process measures against the delivery plan.

Strategic focus areas for the City and Hackney Place-based Partnership

Reducing health inequalities

Giving every child the best start in life (often by recognising the role of families)

Improving mental health and preventing mental ill-health

Preventing and, improving outcomes for people with long-term health and care needs

Population health priority outcome areas

Increasing social connection

Ensuring healthy local places

Supporting greater financial wellbeing

Joining up local health and care services around residents and families' needs

Taking effective action to address racism and other discrimination

Supporting the health and care workforce

Cross-cutting approaches

=Hackney HWB focus area

= Hackney HWB specific 'lenses': (approaches to reducing health inequalities)

= NEL ICS four partnership priority areas

= reflecting LTP response / long term C&H partnership ambitions / Neighbourhoods Programme vision

High Level View of achievements & risks and issues

Key Highlights and achievements

Partnership response to cost of living pressures has enabled us to mobilise a Money Hub- which has directly increased income going to individual households.

Maintaining good operational performance, high quality services and partnership working in the context of severe demand on services and industrial action

Improved outcomes from taking a personalised approach for people with SMI – the use of personal health budgets and a digitised personally held care plan has led to 40% improvements in wellbeing scores

Partnership approach to supporting homeless and vulnerably housed people enabled us to sustain services that were implemented as interim measures during CoVID but have proved to be effective, including the Lowri House step down accommodation, the primary care out-reach service from the Greenhouse and additional housing workers supporting the Pathways homeless team in Homerton and ELFT

Further expansion of our Neighbourhoods model including development of the proactive care service, piloting a Neighbourhood community gyneacology and CVD service, plus we have started to implement four family hubs that map to our Neighbourhoods

Launching an expansive OD programme across Neighbourhoods – this will build relationships across our Neighbourhoods teams and equip staff with skills needed to deliver Neighbourhood

Innovative approach to addressing huge pressures on CAMHS service by expanding the early help and prevention offer for children - particularly across our schools where we have increased Mental health support teams

Key Challenges and Issues

Continued impact of cost of living pressures

High levels of demand on services, particularly urgent and emergency care and adult social care

Industrial action which put more pressure on services and distracted from implementing improvements and/or service developments

Our childhood immunisation and vaccination rates continue to be very low within certain communities – in Springfield Park Neighbourhood we are seeing only 30% coverage of childhood vaccinations at age 1. We have had a number of outbreaks over the last few years, including the recent pertussis outbreak.

Increased prevalence of mental health issues in children and young people – it is estimated that since the pandemic prevalence of a diagnosable condition has increased 10% to 18% across our CYP population.

The Big Ticket Items – How we have progressed

Giving children and young people the best start in life - The Big Ticket Items

1. CYP Emotional Health (Addresses cross cutting approaches: B, C, E, F)

Expected outcomes:	2022/23 Activities	2023/24 Activities	Key risks and Issues:
The outcomes we expect our work around CYP Emotional health to drive include: • Reductions in crisis mental health presentations to ED for CYP • Improvements in mental health and wellbeing outcomes for specific communities	✔ Embedded the new Emotional Health and Wellbeing Partnership to deliver new 0-25 Integrated Emotional Health and Wellbeing Strategy which focuses on a whole system approach to CYP mental health and wellbeing based on the Thrive principles. ✔ Expanded the early help and prevention offer to address the surge in CAMHS demand – this included Tree of Life in schools, Quicksteps Pre-Crisis service, Silver Cloud guided self-help pilot. We also increased capacity in CAMHS 16-25 services. ✔ A new single point of access to CAMHS went live November 22, there is a future ambition to integrate this with the LBH Early Help Single Point of Access ✔ We are slightly below target for the agreed CAMHS access rate with NEL (-9% under). However, C&H remains the highest performing NEL place-base footprint for the number of CYP accessing CAMHS	• Integrated CAMHS fully functioning, including single point of access • Integrated Emotional health and wellbeing strategy action plan being delivered to timescales • Ongoing management of CAMHS demand and supply issues • Super youth hub implemented • Wellbeing And Mental Health in Schools (WAMHS) in all schools, and expansion of Mental Health in Schools Teams (MHSTs)	• *Since the pandemic the estimated Mental Health prevalence rate of diagnosable mental health conditions for CYP in C&H has increased from 10% to an estimated 18%. This is reflected in the referral numbers to CAMHS and the subsequent impact on waiting times.*

2. Children and Young People (CYP) with Complex health needs, Special Educational Needs and Disabilities, (Addresses cross – cutting approaches: B,C,D,E,F)

Expected outcomes:	2022/23 Activities	2023/24 Activities	Key risks and Issues:
The outcomes we expect our work around CYP with Complex health needs, Special Educational Needs and Disabilities, including CYP LD and autism to drive include: • An increase % of children achieving good level of development • Improved health and educational outcomes for those at risk of exclusion • Improved health and educational outcomes for those with complex needs, SEND and autism	✔ Preparation undertaken for SEND inspection – this is still pending but will take place in 2023 ✔ Model and funding and funding agreed for family social prescribing service to provide improved community support for families and pre-and post-diagnostic support. ✔ Agreed delivery plan and Department of Education funding secured to implement integrated family hubs ✔ Funding secured to address clinical backlogs in Autism, learning disabilities, speech and language therapies and occupational therapies. Therapy recruitment remains challenging ✔ Tier 2 audiology Service transferred from Homerton to Barts from 1/4/23 with HHFT funded to address significant backlog over the next 6-8 months – waiting times in the service remain a risk	• Implementation of new autism diagnostic pathways and pre and post diagnostic support • Review of, and recommendations for future of intensive support pathway agreed • Outcomes and recommendations arising from partnership SEND inspection agreed, with delivery plan (likely SEND inspection 2023). • Implementation of family social prescribing and key worker service	• *Lack of visibility of waiting times and activity in SEND services, HHFT statutory performance tracker has been developed and following piloting will be shared with partners* • *Recruitment remains a risk to funded waiting list initiatives and additional capacity* • *Tier 2 audiology waits continue to be long; Barts are now delivering the service but did not take existing long waits. HH are therefore now delivering a backlog reduction programme.*

Giving children and young people the best start in life - The Big Ticket Items

3. Improving uptake of childhood immunisations and vaccinations (Addresses cross cutting approach: A & F)

Expected outcomes:

The outcomes we expect our work around improving uptake of childhood immunisations and vaccinations to drive include:

- Increase immunisation coverage
- Increase % children achieving good level of development
- Increase in LAC health
- Reduce infant mortality rate

2022/23 Activities

- ✔ Developed a system wide plan to address childhood immunisations. This is being delivered, with a flex to respond to the polio booster campaign in 2022.
- ✔ 100% of all children offered the polio booster
- ✔ Implementation of North East Hackney call and recall service, accompanied by dedicated communications campaign.
- ✔ Recruited a Childhood Immunisations Programme Manager and Primary Care Co-ordinator , now recruiting a Family Nurse Practitioner for North East Hackney.
- ✔ Close working with Hatzola as the highly trusted vaccination provider in North East Hackney

2023/24 Activities

- Explore options for devolved commissioning of immunisations and vaccinations to the ICB (currently commissioned by NHSE)
- System plan to improve uptake being delivered, with a range of delivery models
- Any outbreaks effectively managed and addressed

Key risks and Issues:

- *Continued low level of uptake of childhood immunisations across City and Hackney, particularly in North East Hackney*
- *There is no funding to support planning and delivery of rollout, post changes to commissioning arrangements in 2013 when NHSE took on commissioning of immunisations*
- *Limited capacity within primary care and multiple priorities (both clinical and administrative) is a barrier to being able to deliver the programme at pace. This is a particular pressure for CYP vaccines which must be delivered by a registered healthcare professional.*
- *CYP Covid offer has been decreased significantly in line with national guidance. No community pharmacies in C&H vaccinating 5-11 year olds for Covid*

Improving mental health and preventing mental ill-health - The Big Ticket Items

4. Serious Mental Illness (SMI): integrated, personalised support

Expected outcomes:	2022/23 Activities	2023/24 Activities	Key risks and Issues:
• 70% rate for SMI physical health checks • 1,500 Personalised Patient Owned Digital Care Plans • 400 PHBs digitalised linked to personalised care plans • 45%+ significant wellbeing improvement for PHBs	✔ SMI physical health checks are 60.3 % we continue to be the highest PBP in NEL and we are on track to achieve 70% by the end of Q4 ✔ 1,500 Personalised Patient Owned Digital Care Plans were developed, and we are expanding the digital care plan programme into the Early Intervention Services ✔ 400 personal health budgets were given out, each one linked to their digital care plan. We have seen a 45% improvement in well being from the personal health budgets.	• Shift digital plans to real time with bi directional feedback on PROMs • Expand digital care plans beyond SMI	• ***Some practices are struggling to deliver primary health care to their SMI patients.*** *We proposing to offer lower performing practices admin support and also hire an extra HCA to support practice outreach.* • ***Technical issues with Patient Knows best (Digital Care Plans) have led to*** *patients being sent multiple emails whenever the system updates. PKB expansion into EIS services and primary care has been paused. It is estimated that it will take 4-6 weeks to rectify the problem.*

5. Common Mental Health Problems

Expected outcomes:	2022/23 Activities	2023/24 Activities	Key risks and Issues:
• 30% Access rates • 30% increase in LTC access from 2021-22 • 10% increase in BME access from 2021-22	✔ City and Hackney achieved its access target with 29.2 for Q2 – the highest in NEL; We are on target to meet the access target at system level ✔ The IAPT service is working in operation with local foodbanks and employment centres to support people with cost of living pressures. ✔ IAPT is now working collaboratively with HH CAMHS (First steps) to take referrals for 16-25's year olds	• Long term condition (LTC) pathways fully implemented and embedded for all major LTCs with mental health co-morbidity including: diabetes, IBS, COPD, cardiology, oncology	• *Increased complexity of the IAPT caseload are putting pressure on IAPT services. This is particularly challenging as IAPT access targets require a minimum number of new patients to be seen*

Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

6. Enhanced Community Response - 2 hour community response (UCR); Virtual Wards (VW) (PbP element)

Expected outcomes:

- Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach.
- An improved health-related quality of life for people with long term conditions
- A reduction in the inappropriate use of the urgent - emergency care system – which would improve management of urgent care in away from ED
- Reduced mortality / morbidity from emergency presentations
- An improvement in patient experience of urgent care services
- Resident knowledge of urgent and community care services and confidence in using them

2022/23 Activities

- ✔ Work underway to Carry out a stocktake of current Urgent Community Response (UCR) provision in C&H, increase referrals from all routes into UCR and improve data quality and completeness
- ✔ Virtual ward programme established, agreement to implement a VW in for frailty and for respiratory. The model is being finalised

2023/24 Activities

- Continue work to maintain and improve UCR to maximise benefits
- Deliver new Telecare Response Service, ensuring it is integrated into the wider urgent and emergency care services across C+H
- Procurement of End of Life Rapid Response service
- Continued roll out and development of VW provision– ensuring alignment with UEC and exploring opportunity to work across NEL to maximise benefits delivered

Key risks and Issues:

- *Workforce challenges in all areas is impacting on service delivery*
- *Ongoing high levels of pressure on the urgent care system, coupled with industrial action has distracted from delivery of ongoing improvements*
- *Provision of UCR is split across services – increases challenge in providing single point of access and streamlined referral*
- *The virtual ward model is novel, it has been difficult to understand the scope of opportunity and therefore to understand likely demand. The funding envelope is also constrained.*
- *Ongoing high levels of pressure on the urgent care system, coupled with industrial action has distracted from delivery of ongoing improvements*

7. Homelessness and vulnerably housed (Addresses cross cutting approaches: a,b,c,d)

Expected outcomes:

- A reduction in the number of residents in vulnerable housing
- An improvement in the population
- vaccination rates
- An increased engagement with health, social care and wider services

2022/23 Activities

- ✔ Established system and partnership governance for homeless and vulnerably housed. Mapping and review of outreach services completed.
- ✔ Secured an additional year of non-recurrent funding for Lowri House (a 6-bed unit that enables step-down from hospital, or step up from the community), and Routes to Roots Housing workers to match the 2-year funded Pathway Discharge Team working out of the Homerton and ELFT

2023/24 Activities

- Develop Business Case for recurrent funding of Pathway Discharge team, Lowri House step down beds and Routes to Roots Housing Workers.
- LBH and CoIC are developing homeless and rough sleeper strategies in 2023
- Develop primary care homeless service in the City

Key risks and Issues:

- *Sustainability of funding for key services*

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Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

8 Long Term Conditions

Expected outcomes:

- A reduction in premature mortality from cardiovascular and respiratory illness
- Improved blood pressure control in particular within black population
- Improved diabetes outcomes (Blood glucose, blood pressure and cholesterol)
- Accurate diagnosis of diseases to enable correct management and treatment in community – (avoid unnecessary hospital admissions)

2022/23 Activities

- ✔ Improved diabetes care through increased referrals into the NHS Diabetes Prevention Programme (NDPP); launched an awareness and education programme for diabetic foot care in primary care and the community; recruited specialist psychology roles to support people with type 1 diabetes.
- ✔ Worked with our Community champions to deliver a range of community events around diabetes, hypertension and healthy living with our Community Champions
- ✔ 2 year pilot for a Spirometry 'Hublet' approach agreed - Spirometry is one of the essential lung function investigations in the diagnosis, severity assessment and monitoring of many respiratory condition, this will be provided via an outreach offer in Neighbourhoods provided by the Homerton ACERs services.
- ✔ Agreed the specification for a post-stroke community support service – we will go to procurement in 2023.
- ✔ Developing Risk Stratification approaches within primary care to identify high risk individuals and offer proactive care to improve management of their LTC and to reduce their risk of experiencing adverse event/unplanned admission in relation to their condition.

2023/24 Activities

- Re-engage with PCNs to roll out Low Calorie Diet for Type 2 diabetes remission to remaining practices.
- Launch digital structured education offer for Type 2 Diabetes
- Roll out PCN Diabetes Covid recovery scheme to increase diabetes care processes completion
- Implementation of Blood Pressure Monitoring (BPM) @ Home from all practices
- Implementation of 2 year pilot spirometry service to be delivered by ACERs in primary Care

Key risks and Issues:

- *NEL clinical leadership restructure may affect future delivery of projects*
- *BMP@Home Risk: Practices not wanting to signup to programme:*
- *Not having volunteers to distribute BP monitors to practices*
- *Capacity of some PCNs to engage with an additional programme. Engaging directly with interested practices in these cases.*

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Preventing and improving outcomes for people with long-term health and care needs - The Big Ticket Items

9. Discharge

Expected outcomes:	2022/23 Activities	2023/24 Activities	Key risks and Issues:
• An improvement in health-related quality of life for people with long term conditions • Making sure more people are able to live independently for longer	✔ Significant partnership response to strike action mobilised through the year – ensuring that flow was maintained during particularly pressured times ✔ Homerton discharge performance remained above the London and National averages ✔ Independent review of C&H Discharge pathways undertaken – awaiting final recommendations and action plan to be developed. ✔ Flow initiatives in ELFT put in place, utilising BCF monies, in order to reduce pressure on mental health capacity.	• Implementation of improvement plan / recommendations from Discharge Review	• *There is no long term funding settlement for adult social care* • *Any Discharge funding is non-recurrent and short term. This limits our ability to plan and deliver improvements*

10. Supporting Residents with cost of living

Expected outcomes:	2022/23 Activities	2023/24 Activities	Key risks and Issues:
• Maximising individual and household incomes via improved access to all available benefits • Reduction in people becoming homeless • Ensuring all residents have access to healthy and wholesome food • Ensuring residents can keep their homes warm	✔ Rolled out a programme of training and information to all of our front line workforce to help equip them with the tools needed to support their clients/patients with cost of living pressures. This included implementing a direct referral service from a selection of services so that their clients/patients could access up to £200 emergency funding from the household support fund ✔ Set up food and advice networks across the voluntary sector to support local community organisations to provide vital services within each Neighbourhood ✔ Our community partners mobilised over 25 warm hubs which we advertised through the council and in Neighbourhoods ✔ We launched the money hub in November 2022 which provides advice and direct access to benefits for residents – this in on track to bring in an additional £1m of income to our residents in its first year of operation ✔ Implements a 'Green Doctor' scheme in the City to support residents to improve the energy efficiency of their homes	• Develop a sustainable model for the Money Hub – which is currently funded non-recurrently • Integrate the Equipping Front Line staff programme into existing and BAU staff training, particularly in Neighbourhoods • Continue to develop our food and advice networks, using learning from what has worked so far	• *Poverty continues to be a critical issue for many residents, inflation in continuing to grow and local action will be insufficient to completely tackle this*

The City and Hackney Place Based Neighbourhoods Programme

Cross cutting approaches:			
	a **=** Ensuring healthy local places	***b*** **=** Joining up local health and care services around residents and families' needs	***c*** **=** Increasing social connection
	d **=** Supporting greater financial wellbeing	***e*** = Taking effective action to address racism and other discrimination	***f*** = Supporting the health and care workforce

2022 - 2024 Transformation Area **Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f**	**2022-23 Activities & Progress Made**	**2023-24 Plan**	**Key risks and Issues:**
The outcomes we expect each action area to drive: • Staff are actively working 'upstream' on prevention and addressing rising needs • There are Neighbourhood System Partner Plans in place focused on prevention and rising needs • Staff have a clear understanding of the pathways to multi-agency forums to discuss resident's needs at an early help level • Patients and service users receive the care they need when and where they need it • Staff are confident at information sharing across agencies in a proactive way using information sharing agreements and best practice	**Neighbourhoods Priority 1: Addressing Rising Need** New Neighbourhoods anticipatory care pathway for frailty developed. It includes a participatory budget for each Neighbourhood to develop a specific service Community Navigation Strategy launched. Neighbourhoods navigation networks put in place which bring together the workforce in each Neighbourhood to share resources and provide peer support. Community navigation services have been mapped an a guide has been developed for professionals **Neighbourhoods Priority 2: Driving and improving multidisciplinary teams** Partnership agreement to collaboratively develop an options appraisal for the development of Neighbourhood teams Agreement to develop four family hubs that map to the Neighbourhoods footprint and bring CYP services into the Neighbourhoods model **Neighbourhoods Priority 2: Driving and improving multidisciplinary teams** Neighbourhoods organisational development programme launched, supported by the workforce enabler. This will provide training and events that build relationships in Neighbourhoods and equip staff with new skills to support Neighbourhood working. **Neighbourhoods Priority 4: Embedding a structure for resident involvement in Neighbourhood decision making** Neighbourhoods forums have been established, bringing together voluntary sector, residents and statutory partners in each Neighbourhood. They are developing their own priorities Neighbourhoods public facing website launched Full evaluation of the Neighbourhoods programme has been started undertaken by Renaisi	• Continue to mobilise and develop the Proactive care pathway with residents, the OoPCNs and other partners • Operationalise the Community Navigation strategy • Implement the next phase of Neighbourhoods teams • Full delivery of the OD plan • Further work to increase resident involvement in Neighbourhoods forums, • Establish Neighbourhoods leadership teams	• *The ICB financial position could impact funding allocated (from ageing well) for spending on the proactive care pathway.* • *Multiple barriers to moving funds between organisations to develop the proactive care pathway.* • *Staff working in the proactive care team are all on fixed term contracts which could lead to instability for the service.* • *Work on the options appraisal paper will need much collaborative working/resource between system partners to envisage the most appropriate model of Neighbourhood teams for City and Hackney* • *The evaluation is highly complex and we may not have the right data to establish meaningful findings against all domains*

Appendix: The Full Integrated Delivery Plan

Strategic Priority: Giving children and young people the best start in life.

***Addressing Cross cutting approaches**:*
a = Ensuring healthy local places;
b = Joining up local health and care services around residents and families' needs;
c = Increasing social connection;
d = Supporting greater financial wellbeing,
e = Taking effective action to address racism and other discrimination;
f = Supporting the health and care workforce

Partnership Leads : Amy Wilkinson, Chris Pelham, Ellie Ward, Jacquie Burke, Sarah Wilson

Strategic Priority: Giving children and young people the best start in life

City and Hackney PbP Programme/s: Children, Young People, Maternity and Families

Cross cutting approaches:			
	a = Ensuring healthy local places	***b*** = Joining up local health and care services around residents and families' needs	***c*** = Increasing social connection
	d = Supporting greater financial wellbeing	***e*** = Taking effective action to address racism and other discrimination	***f*** = Supporting the health and care workforce

2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
1. **AREA OF PRIORITY/ BIG TICKET ITEM** **CYP Emotional Health** (Cross cutting approach: B, C, E, F) *We are prioritising earlier prevention and wellbeing for children and families. In line with our new Integrated Emotional Health and Wellbeing Partnership action plan, we continue to ensure CAMHS recovers capacity through integration and strengthening support for our vulnerable groups, around eating disorders, crisis and transition.*	The outcomes we expect our work around CYP Emotional health to drive include: • Reductions in crisis mental health presentations to ED for CYP • Improvements in mental health and wellbeing outcomes for specific communities	• Embed new Emotional Health and Wellbeing Partnership enabling **better joint working and collaboration** and shared objectives (delivers our new 0-25 Integrated Emotional Health and Wellbeing Strategy) • **Continue to manage the surge in CAMHS, implementing mitigation to** prevent system failure and clearing referral backlog. • Work with LBH comms team to **improve uptake of the IAPT** service for 18-25s and work on SCAC assessment clinic, including waits. • **Establish the single point of access and progress CAMHS integration. Plans agreed.** • **Further align priorities across NEL and the NEL CAMHS priorities**. Significant pressures in the outer boroughs. • Agree, and commence deliver of co-produced **Eating Disorder action plan** (more investment in community provision and family support)	• Scope and **develop LGBTQ emotional wellbeing offer** for young people and schools • Continue **to implement CAMHS integration**, exploring SPA co-location with early help hub • **Continue to manage the surge in CAMHS, and implement mitigations** • Development of **super youth hub** design with partners (may include primary care, secondary care, CAMHS and universal health provision) • Expand the **Wellbeing and Mental Health in schools programme** from 80% coverage to 100% of schools (MHSTs in 75% of schools) • Further roll out of **OJ WAMHS in independent** schools and launch OJ families clinical service • Refresh and re-launch of **Young Black Men's Mental health** partnership and workplan	• Integrated CAMHS fully functioning, including single point of access • Integrated Emotional health and wellbeing strategy action plan being delivered to timescales • Ongoing management of CAMHS demand and supply issues • Super youth hub implemented • WAMHS in all schools, and expansion of MHSTs • Further targeted work for on reducing inequalities for specific groups being delivered	Amy Wilkinson, Greg Condon, Sophie McElroy, Mariona Garcia, Chris Pelham, Julie Proctor, Mags Farley, Temitope Ademosu

Strategic Priority: Giving children and young people the best start in life

City and Hackney PbP Programme/s:	Children, Young People, Maternity and Families		
Cross cutting approaches:	***a*** **=** Ensuring healthy local places	***b*** **=** Joining up local health and care services around residents and families' needs	***c*** **=** Increasing social connection
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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
2. **AREA OF PRIORITY/ BIG TICKET ITEM** **Children and Young People (CYP) with Complex health needs, Special Educational Needs and Disabilities, including CYP LD and autism** (Cross – cutting approach: B,C,D,E,F) *In line with the Long Term Plan, our ambition is to strengthen integrated working across the system to identify and meet 'needs' early and holistically, and continuing the development of our multi agency early help for families.*	The outcomes we expect our work around CYP with Complex health needs, Special Educational Needs and Disabilities, including CYP LD and autism to drive include: • An increase % of children achieving good level of development • Improved health and educational outcomes for those at risk of exclusion • Improved health and educational outcomes for those with complex needs, SEND and autism	• Embed joint C&H commissioning arrangements, specifically for those with **LD / Autism and children with complex needs** • Improve community provision through **families social prescribing, key working and pre and post diagnostic support** (funding secured: interventions to be scoped) • Development of the **early help hub and integrated family hubs** with system partners • Address **clinical backlogs** (funding secured), and support **development of therapies** (ASD, LD, SLT and OT) • Agree enhanced **ICOT service spec** (with LBH) • Support improvements in **paediatric staffing** • Ensure **risk managed and full transfer of T2 audiology** from HUFT to Barts by August 2022	• Deliver CYP components of **the 'All Age Autism Strategy'** and Long Term Plan priorities (through Emotional H&WB Partnership's *Neurodevelopmental subgroup)* • Invest in and design improved **autism diagnostic pathways** and capacity for **pre and post diagnostic** support • Pilot and ongoing evaluation of the **Intensive Support Pathway** and timely multi agency assessments to reduce crisis • Coproduced design and pilot **key worker roles** to inform joint commissioning • Development of pupil voice **co production of Autism and LD pathways**, professional and families' resources and training • **Integrated workforce training** for SEND via Hackney Education • Autism is a shared priority across NE:C&H leading **development of ICS SEND governance**	• Implementation of new autism diagnostic pathways and pre and post diagnostic support • Review of, and recommendations for future of intensive support pathway agreed • Outcomes and recommendations arising from partnership SEND inspection agreed, with delivery plan (likely SEND inspection 2022). • Agreed and functioning ICS SEND governance in place	Amy Wilkinson, Sarah Darcy, Ellie Duncan, Nick Wilson, Huw Bevan, Mags Farley, Chris Pelham and Donna Thomas

Strategic Priority: Giving children and young people the best start in life

City and Hackney PbP Programme/s: Children, Young People, Maternity and Families

Cross cutting approaches:			
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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Oct -22 to Mar-23	2023 - 2024 Apr-23 to Mar -24	Leads
3. <u>AREA OF PRIORITY/ BIG TICKET ITEM</u> **<u>Improving uptake of childhood immunisations and vaccinations</u>** (Cross cutting approach: A & F) *Our goal is to increase the uptake of childhood and pregnancy immunisations including Covid vaccination. However, the immediate focus is the recovery of childhood immunisations, across all of C&H, in order to prevent potential outbreaks.*	The outcomes we expect our work around improving uptake of childhood immunisations and vaccinations to drive include: • Increase immunisation coverage • Increase % children achieving good level of development • Increase in LAC health • Reduce infant mortality rate	• Development of **refreshed system plan:** outlines targeted offer in North C&H (jointly funded immunisations co-ordinator and team, family clinics, use of call / recall), with PCNs • Recruitment of **Childhood Immunisations Programme Manager** • Recruitment of **Childhood Immunisations Primary Care co-ordinator** • Support **NEL LIS** implementation • Agree C&H **outbreak prevention plan** (ie. MMR uptake and measles) • Ongoing focus on improving uptake of **CYP covid vaccinations**	• Agree with VSC partners community offer for **specific communities** (funding secured • Ongoing **implementation of system plan** and increased delivery • Explore **enhanced delivery models** for routine childhood immunisation (ie. family hubs, children's centres, universal services).	• Explore options for devolved commissioning of immunisations and vaccinations • System plan to improve uptake being delivered, with a range of delivery models • Any outbreaks effectively managed and addressed.	Sarah Darcy, Teresa Cleary, with Richard Bull and Ellen Schwarz
<u>Improving healthy weight</u> (Cross cutting approach: A & B) *This work is in collaboration with public health in City and Hackney, to design and implement a family approach to healthy weight.*	The outcome we expect around our work in improving healthy weight to drive is **to reduce childhood obesity**.	• Support public health to **re-commission of children's health weight services** • Agree **spec for CYP Tier 2 healthy weight interim service**	• Design **families healthy weight pathway** including maternal element • Ongoing work with public health on **psychological aspects** of healthy weight services • **Implement CYP Tier 2 healthy weight interim service**	• Implementation of family healthy weight pathway and services	Jayne Taylor, with Amy Wilkinson and Donna Doherty-Kelly
<u>Childhood Adversity, Trauma and Resilience</u> (Cross cutting approach: B,C,E,F) *We are continuing to support system professionals working with families, to address the impact of adverse childhood experiences (ACEs), through our Childhood Adversity, Trauma and Resilience workforce training, resource portal, pilot interventions and system wide approach.*	*N/A*	• **Embed ACEs/TIP approaches within service delivery** long term across the C&H system (health, education, social care, VCS) through ongoing roll out of **workforce training sessions.** • **Recruitment of a project manager** • Refresh **Project Steering Group** • Set out a plan for recruiting and retaining a **pool of development session facilitators** • **Agree Anti-Racism approach across health services** as part of wider LBH Children and Education AR plan	• **Agree evaluation programme** • With the population health hub, deliver a needs analysis for our **Youth Justice cohort** and identify gaps in health interventions • **Implement our anti-racist approach** across all areas • Ongoing **workforce development** and delivery of training and support • Further roll out of **trauma informed child protection conferences** (TBC)	• Deliver Evaluation of CHATR work • Implementation of increased health support for youth justice cohort, as per recommendations of HNA and scoping • Anti- racist approach embedded widely • Further interventions as CHATR work develops.	Matt Hopkinson and Teresa Cleary

Strategic Priority: Giving children and young people the best start in life

City and Hackney PbP Programme/s: Children, Young People, Maternity and Families

Cross cutting approaches:			
	a **=** Ensuring healthy local places	***b*** **=** Joining up local health and care services around residents and families' needs	***c*** **=** Increasing social connection
	d **=** Supporting greater financial wellbeing	***e*** = Taking effective action to address racism and other discrimination	***f*** = Supporting the health and care workforce

2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
<u>Maternity (PbP element)</u> **(Cross cutting approach: B,C, E, F)** *Working with NEL, we aim to continue to deliver safe maternal and birth outcomes and national service transformation.* *Locally, we have a priority to* • *Reduce inequalities and improve outcomes in Neonatal mortality, infant mortality and stillbirths* • *Improving women's experiences of maternity, specifically the most vulnerable women through education and co-production with service users, MDT staff training and partnership working with all clinical and social care teams.*	The outcomes we expect our work in maternity and perinatal mental health to drive include: • A reduction in infant mortality rate • A reduction in the rate of neonatal mortality and stillbirths • A reduction in inequalities in maternity and birth outcomes for children and families • An improvement in patient experience and outcomes for groups experiencing inequalities in Maternity and perinatal mental health care.	• Support ongoing **safe and effective service** while undergoing leadership changes, • Implementation of **Ockenden report recommendations** (ie. recruitment of additional workforce) • collaboration with GP confederation to increase use of **maternity link meetings and MDTs** • Improve uptake of covid-19 vaccines in pregnancy • Ongoing support **for refugee and migrants maternity needs**, including Afghan and Ukraine arrivals.	• Support the procurement of **a new digital system** in the maternity service and ambition for outstanding CQC. • Launch the **Vulnerable Women's Pathway** at a GP Education Session. • Implementation phase of the **6 month postnatal GP check** • Roll out of **trauma informed midwifery training** and increasing access to birth debrief sessions • Development of **system partner plan to reduce health inequalities** in maternal and baby birth outcomes (also see perinatal mental health)	• New digital system in place • Workforce at increased capacity as a result of ongoing recruitment (linked to Ockenden report) • New pathway work identified • System plan to reduce health inequalities in maternal and baby health outcomes being delivered	Amy Wilkinson, Jairzina Weir, Linda Machakaire, Tamsin Bicknell and Ellie Duncan
<u>Peri-natal mental health</u> **(Cross cutting approach: B, C, E, F)** *We are working to ensure professionals, women and birthing people are aware of the perinatal service offer and how to access this in order to improve outcomes, and to continue to develop services that meet local need and address inequalities.*		• Mobilise the **MMHS / OCEAN (Maternity Mental Health Service)** • **Address recruitment challenges** to have all services (OCEAN, Perinatal and debrief) fully staffed and operating a capacity. • **Create awareness of the perinatal service offer and 'how to refer'** among professionals and women • Work with the LBH CYP Overview and Scrutiny committee to develop an **action plan to improve inequalities in perinatal mental health**	• **Ongoing implementation and embedding of MMHS / OCEAN** • **Improving the data output** from the perinatal service • Ongoing work to **implement recommendations** on address **inequalities in perinatal mental health**	• Fully functioning MMHS / OCEAN service • Robust data systems in place, supporting work to improve perinatal and maternity mental health outcomes • Ongoing delivery of recommendations to address inequalities in maternal mental health	

Strategic Priority: Giving children and young people the best start in life

City and Hackney PbP Programme/s: Children, Young People, Maternity and Families

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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
Safeguarding and Looked After Children (PbP element) (Cross cutting approach: B,C,F) *We are continuing to prioritise the health, wellbeing and safeguarding needs of Looked After Children (LAC) and Unaccompanied Asylum Seeking Children (UASC), locally and with NEL colleagues.*	Safeguarding outcomes – TBC Contributes to: - Reduce infant mortality - Increase in health of LAC	• Support embedding of new **Integrated Care Board safeguarding and LAC structures** • **Support new CDOP arrangements** and consider how we capture the feedback from families. • **Develop and facilitate C&H safeguarding training** programme for Primary Care Networks and neighbourhood • Design and pilot **public health approach to trauma** in schools and the wider community, specifically addressing racism, adultification and children's rights. ('Hackney Thinking Spaces') **Pilot in 2 schools**. • **Transition HLAC service to caseload management** • **Deliver Foster carer training**	• Agree and implement **safe C&H PBP Safeguarding and LAC** arrangements and ongoing close working as part of C&H Safeguarding Children's Partnership • Continue to deliver schools and communities therapeutic interventions (co-designed), on adultification, children's rights, and racism (**Hackney 'Thinking Spaces**') • Roll out of training on the above to NEL health professionals • To further **develop a robust system for capturing relevant data**. • On-going **engagement with young people** to evaluate the HLAC service and inform service development • Improve **LAC dental check and immunisation** compliance	• Embedded new ways of working for safeguarding children and LAC across the ICB and PBP • Continued roll out of Thinking Spaces' • Health of Looked after children's dental health and immunisation compliance interventions ongoing	Mary Lee, Sam Martin and Anna Jones, with Rory McCallum and Chris Pelham
Neighbourhoods (Cross cutting approach: A,B, F) *We aim to take a proactive and collaborative approach to supporting Children and young people with rising needs through improving pathways and collaboration at Neighbourhood level and embedding a whole family approach.*	N/A	• **Embed Primary Care input into MDT discussions for 0-5 years** and links with adult teams across all Neighbourhoods. • Develop **proactive care approach to support children and young people who are absent from school or who have complex health conditions** (strengthen teams around the child / school and link school, primary care and secondary care together): **Pilot in 10 schools.** • **Increase knowledge and awareness of practitioners at PCN level by** compiling a directory, refining pathways and strengthening relationships. • Work on establishing **joint action plans** with PCN's depending on their identified priorities. • Agree enhanced **Speech Language therapy offer for under 5's**	• Test approaches to **social prescribing at PCN level for children and families**, alongside NEL partners. Pilot social prescribers in some PCNs. • Further roll out of **schools & Primary / Secondary care link programme,** building on pilot • Recruit practitioner and **begin delivery of 0-5 SLT neighbourhood offer** • **Public directory,** linked to early help, family hub and navigation work	• Embed Families social prescribing offer across PCNs • All schools working more closely with health partners • Embedding of neighbourhood level SLT offer for under 5's. • Additional interventions to be agreed.	Rachel Wicks, Brittany Alexander, Annabelle Burns, Chris Pelham
Key actions to address inequalities: • Outlined throughout and embedded in the key actions		• See above	• See above	• See above	

Strategic Priority: Improving mental health and preventing mental ill-health

Addressing Cross cutting approaches:
a = Ensuring healthy local places;
b = Joining up local health and care services around residents and families' needs;
c = Increasing social connection;
d = Supporting greater financial wellbeing,
e = Taking effective action to address racism and other discrimination;
f = Supporting the health and care workforce

Partnership Leads : Dan Burningham, Dean Henderson, Chris Pelham, Ellie Ward

Strategic Priority: Improving mental health and preventing mental ill-health

City and Hackney PbP Programme/s : **Mental Health and Learning Disability**

Cross cutting approaches:			
	a **=** Ensuring healthy local places	***b*** **=** Joining up local health and care services around residents and families' needs	***c*** **=** Increasing social connection
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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
1. AREA OF PRIORITY/ BIG TICKET ITEM **Serious Mental Illness (SMI): Delivering Integrated Personalised Care** *(Cross – cutting approach: a,b,c,d,f)* *Our approach involves increasing personalised care and access to financial support from personal health budgets as part of a pathway that integrates physical and mental health and promotes resilience in the community and which prevents a deterioration in mental state and reducing the need for crisis services*. Digitalisation supports both staff and service users.	The outcomes we expect our work in Serious Mental Illness to drive include • 70% rate for SMI physical health checks • 1,500 Personalised Patient Owned Digital Care Plans • 400 PHBs digitalised linked to personalised care plans • 45%+ significant wellbeing improvement for PHBs This should support a reduction in SMI excess mortality	• Complete PHC coding for PHB • Implement PHB in EIS teams	• Complete implementation of PKB in primary care and Recovery College • Review service user feedback on implementation • Complete Discovery data pairing project to track PKB use.	• Shift digital plans to real time with bi directional feedback on PROMs • Expand learning beyond SMI	Dr Olivier Andlauer((Clinical Director)
2. AREA OF PRIORITY/ BIG TICKET ITEM **Common Mental Health Problems** *(Cross – cutting approach: a, b, c, d, e)* *We aim to improve access for underserved populations including those with long term conditions, those experiencing economic hardship and underserved BME populations*	The outcomes we expect our work in Common Mental Problems to drive include • 30% Access rates • 30% increase in LTC access from 2021-22 • 10% increase in BME access from 2021-22	• Treatment offer of assistance with financial anxiety to foodbanks and employment centres • Appoint LTC lead to develop LTC pathways • Start discussions with HUH health psychology departments to design new pathways • Develop offer for 16-18 year olds	• Monitor increase in treatments to people with out work • Complete pathway design work with HUH health psychology departments	• LTC pathways fully implemented and embedded for all major LTCs with mental health co-morbidity including: diabetes, IBS, COPD, cardiology, oncology.	Jon Wheatley (Talk Changes IAPT Clinical Lead)
3. AREA OF PRIORITY/ BIG TICKET ITEM **CAMHS: whole system integrated appoach** *(Cross – cutting approach: a,b,c,e,f)* *We are addressing rising levels of demand and acuity through* *a) greater pathway integration between providers* *b) A whole system approach using the THRIVE which focuses on early identification, prevention and promotion with all those involved in the lives of children and young people* ***This forms part of the emotional approach to***	The outcomes we expect our work in CAMHS include: • CAMHS access 0-18 access rate of 3,707 by Q4 2022/23 • RTT waiting times held static against rising demand or improved. • Better patient experience of referrals • Higher referral conversion rates • THRIVE planned in accordance with the THRIVE tool kit with implementation started	• Monitor RTT waiting times and avoid deterioration • Improve the digital offer • Agree whole system approach using Thrive model with a full project plan • Single Point of Access Implemented	• Agree an integration plan between providers • Implement 24/7 Home treatment teams • 100% roll-out of Universal WAHMS to all state maintained schools • Single point of access expanded. • Begin implementation of THRIVE	Complete implementation of THRIVE and further develop the model	Greg Condon CCG City and Hackney PBP CAMHS lead

Strategic Priority: Improving mental health and preventing mental ill-health

City and Hackney PbP Programme/s : **Mental Health and Learning Disability**

Cross cutting approaches:			
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2022 - 2024 Transformation Area **Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f**	**The outcomes we expect each action area to drive**	**Key Milestones**			**Leads**
		2022 - 2023		2023 - 2024	
		July-22 to Sep-22	Oct -22 to Mar-23	Apr-23 to Mar -24	
<u>Dementia</u> For dementia, we have an ambition • To improve the community diagnosis to end of life community service to prevent the unnecessary use of A&E and inpatient admissions. • To reduce lengths of stay through improving the discharge pathway ***An essential area identified to support the health of our population is to ensure there is reduction in the rate of hospital admissions for patients with dementia for non medical i.e. social reasons***	The outcomes we expect our work in Dementia to drive include: • 95% + of those with a dementia diagnosis will be open to the diagnosis to end of life service. • More than 66.7% of the dementia prevalence rate will be diagnosed • Average weighting time referral to diagnosis will be under 80 days (2021-22 baseline: 90 days). • Reduction in hospital admissions and lengths of stay and A&E use against baseline.	• Establish baseline data for inpatient admissions and A&E usage and lengths of stay • Agree plan to reduce lengths of stay • Expand VCSE BME offer • Achieve and improve NHSE diagnostic target • Establish base line for CMC plan updates	• Implement plan to improve discharge pathway • Review inpatient admissions and A&E attendances • Improve CMC plan updates • Monitor diagnostic rate • Monitor DTC dementia rate • Transition care plans onto new digital platform • Improve breadth of community offer.		Fawzia Bakht CCG City and Hackney PBP Dementia Lead Adenike Saidu (MHCOP)
<u>Learning disability and Autism (LD&A)</u> **(PbP element)** (Cross cutting approach – a,b,c,e) *Both coproduced strategies for learning disabilities and autism seek to have accessible, autistic and learning disabled friendly communities for these underserved groups. The Transforming Care is a specific programme to ensure those with behaviour that challenges services (who are autistic or learning disabled) are enabled to live within community settings and avoiding unnecessary hospital admissions* **<u>Specific actions to address inequalities:</u>** • Accessibility of services to LD / autism • LD / autism patients receiving full health check	This means ensuring good access to mainstream services; strengths-based community approaches and promoting independence, choice and control.	• Establish Autism Coordinator one year post to focus on developing an Autistic Friendly Neighbourhood • Circulate STOMP Audit findings • Promote Annual Health Checks (AHCs) among GPs & practices to encourage update and support preventative approaches	• Review crisis support roles in LD&A to determine effectiveness at keeping people out of hospital • Ensure one of the Capital Funded changing places toilets is on the Changing Places Map to meet requirement of the bid and promote a more accessible community • Establish an agreed provider list for day services.	• Review autistic friendly neighbourhood pilot progress. • Maintain inpatient trajectory for Transforming Care to ensure no unnecessary admissions to mental health or acute treatment units.	Penny Heron
<u>Crisis Pathway</u> To reduce the pressure on A&E and inpatient services through better alternatives		1. Agree plan to integrate crisis line with NH and TH to improve back up 2. Implement plan to reduce MH A&E breaches	1. Implement improved crisis line 2. Monitor reduction in A&E breaches		Andrew Horobin (ELFT Mental Health Crisis Lead)

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

***Addressing Cross cutting approaches**:*
a = Ensuring healthy local places;
b = Joining up local health and care services around residents and families' needs;
c = Increasing social connection;
d = Supporting greater financial wellbeing,
f = Supporting the health and care workforce

Partnership Leads : Charlotte Painter, Chris Pelham, Anna Hanbury, Ellie Ward, Mags Shaughnessy

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

The Partnership leads are Charlotte Painter, Chris Pelham, Anna Hanbury, Ellie Ward, Mags Farley, Mags Shaughnessy Others TBC

City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

Cross cutting approaches:

a = Ensuring healthy local places	***b*** = Joining up local health and care services around residents and families' needs	***c*** = Increasing social connection
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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
1. **AREA OF PRIORITY/ BIG TICKET ITEM** **Enhanced Community response - 2 hour community response (UCR)** ***In terms of delivery, we are focused on:*** • ***Supporting people in crisis at home as safe alternative to ED -*** *Meeting patients' urgent care needs at home is key to improving patient outcome and reduces pressure in urgent and emergency care system (UEC)* • ***Improving access, responsiveness and patient safety -*** *increasing activity managed in community, with minimum of 70% referrals seen in 2 hours – reassures patients and partners.* • ***Improving consistency and patient experience –*** *ensuring equity of access and supporting referrals from system partners* • ***Improving data –****providing assurance around levels of activity and outcomes. (exploring opportunity for improvement within variation)* • ***Improving post crisis care –*** *providing continuum of care to ensure full recovery / independence and reduce risk of further crisis*	The outcome we expect our work in Enhanced Community response to drive include: • Ensuring that people with long term health needs are better supported in their own home through a more personalised and proactive approach. This is to help people: - Avoid crisis - Recover more quickly from crisis / acute episode - Maintain health – return to pre-morbid health - Live independently for longer - improved wellbeing • An improved health-related quality of life for people with long term conditions • A reduction in the inappropriate use of the urgent - emergency care system – which would improve management of urgent care in away from ED • Reduced mortality / morbidity from emergency presentations • An improvement in patient experience of urgent care services • Resident knowledge of urgent and community care services and confidence in using them	• Stocktake of current UCR provision in C&H: • confirm continued delivery of minimum requirements against standard • Consider potential opportunities to increase activity managed in community & maximise benefits and outcomes (variance, shared learning & best practice) • Agree development plan based on outcome of stocktake • Continue (& embed) existing work to increase referrals from all routes into UCR • LAS push pilot • Self referral into Integrated Independence Team Rapid Response (IIT RR) • Telecare falls pathway • UCR communication and awareness – including decision support tool • Work with NEL partners to agree key outcomes for UCR & identify opportunity for consistencies in provision that will support delivery of them (facilitating referrals & effective delivery model) • Improve UCR data quality & completeness – review current reporting via community services data set (CSDS) & agree work plan to ensure accurate measure of provision • *Consider business case for local investment in Telecare provision (enhanced health response)* • *System agreement of End of Life Rapid Response service model and specification*	• Implement development plans agreed in Q3 • Review demand & capacity following initiatives to increase activity and agree workforce plan as required • Integrate UCR with emerging virtual ward provision • *Work in partnership with LBH to develop and commission a Telecare Response Service specification. Ensuring alignment with and integrated in C&H urgent and emergency care services* • *Procurement of End of Life Rapid Response service (Oct-Jan) and mobilisation of service (Feb-Mar)*	• *Continue work to maintain and improve UCR to maximise benefits* • *Work in partnership with LBH to ensure that when delivery commences of a Telecare Response Service it is integrated in C&H urgent and emergency care services with integrated pathways between services* • *New End of Life Rapid Response service goes live April 23*	Anna Hanbury, Mags Shaughnessy ,Mags Farley

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

The Partnership leads are Charlotte Painter, Chris Pelham, Anna Hanbury, Ellie Ward, Mags Farley, Mags Shaughnessy Others TBC

City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

Cross cutting approaches:

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2. **AREA OF PRIORITY/ BIG TICKET ITEM** **Enhanced Community Response – Virtual Wards (VW) (PbP element)** ***A virtual ward*** *is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home.* **So we are introducing / expanding provision of enhanced healthcare at home as an alternative to acute bedded care and** • *supporting patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home*	***As above (for urgent community response)***	• Set up C&H VW programme governance (including supporting enabler groups) • Finalise design of C&H virtual ward model for frailty and ARI • Develop / agree service development proposals (utilisation of VW service development funding) • Agree evaluation framework/approach - data to measure performance /outcomes and inform development of model	• Mobilisation of plan – implementation of service development proposals • Ongoing evaluation to inform a quality improvement (QI) approach to VW model development • Dec 2022 – NHSE assurance gateway, review of delivery for further release of funding	• Continued roll out and development of VW provision– ensuring alignment with UEC	Anna Hanbury Leah Herridge Annabelle Burns Mags Shaughnessy Mags Farley
3. **AREA OF PRIORITY/ BIG TICKET ITEM** **Homelessness and vulnerably housed** (Cross cutting approach – a,b,c,d) *This programme of work involves partnership working across health, social care and housing to* ***ensure the vulnerably housed with City and Hackney have integrated health, housing, care, employment and community pathways*** *that support a sustainable move away from homelessness resulting in improved health and social outcomes.*	The outcome we expect our work around Homelessness and vulnerably housed to drive include: • A reduction in the number of residents in vulnerable housing • An improvement in the population • vaccination rates • An increased engagement with health, social care and wider services	• Mapping and review of health outreach services across NEL. • Establishing clear governance structure across North East London and City and Hackney Place-based Partnership for vulnerably housed • Securing an additional year of non-recurrent funding for Lowri House (a 6-bed unit that enables step-down from hospital, or step up from the community), and Routes to Roots Housing workers to match the 2-year funded Pathway Discharge Team.	• Work with National team on evaluation of Lowri House • Evaluation and development of a business case for recurrent funding for the Housing First service. This is a service for entrenched rough sleepers with complex and multiple needs. Housing First prioritises access to housing and eligibility is not contingent on engaging with support. Flexible support is provided for as long as it is needed.	• Write Business Case for recurrent funding of Pathway Discharge team, Lowri House step down beds and Routes to Roots Housing Workers. • .	Cindy Fischer Fawzia Bakht Eamann Devlin Arto Matta Jennifer Wynter, Will Norman

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

The Partnership leads are Charlotte Painter, Chris Pelham, Anna Hanbury, Ellie Ward, Mags Farley, Mags Shaughnessy Others TBC

City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
4. AREA OF PRIORITY/ BIG TICKET ITEM **Long Term Conditions (PbP element)** (Cross cutting approach – a,b,c) *Working with partners across the System, we aim to continue to drive up the quality of care and outcomes for people living with long term conditions (LTCs). This programme of work aims to embed preventative approaches, increase standards and reduce variability in access to high quality care, and increase the proportion of patients feeling supported to manage their LTCs. We are enabling this through;* • *Continued commissioning of the LTC contract for City & Hackney practices to deliver high quality preventative care above their core contracts, with a new focus on embedding risk stratification approaches and addressing inequalities;* • *Roll out of, and increasing referrals into local and national programmes of education and self-management support for LTCs, including digital technologies to support this;* • *Drawing upon the expertise and resources of people with LTCs and their communities to help achieve the best possible outcomes and drive reductions in inequalities.* **Specific action to address inequalities:** • *Inequalities and risk stratification focus included in LTC Contract* • *Collaborative work with Community Champions* • *HTN BP control (BAME)*	The outcomes we expect our work on Long Term Conditions to drive include: • A reduction in premature mortality from cardiovascular and respiratory illness • Improved blood pressure control in particular within black population • Improved diabetes outcomes (Blood glucose, blood pressure and cholesterol) • Accurate diagnosis of diseases to enable correct management and treatment in community – (avoid unnecessary hospital admissions)	• Launch Risk Stratification approaches within the LTC contract to identify high risk individuals and offer proactive care to improve management of their LTC and to reduce their risk of experiencing adverse event/unplanned admission in relation to their condition. Inequalities element also to be launched, specifically focusing on completion of Diabetes annual review, Hypertension blood pressure targets, and prescription of statins for patients at risk of CVD. • Roll out Blood Pressure @ home to all practices • Roll out Low Calorie Diet pilot for Type 2 diabetes weight loss and remission, to all PCNs. • Agree Spirometry Hublet approach - Spirometry is one of the essential lung function investigations in the diagnosis, severity assessment and monitoring of many respiratory conditions • Circulate findings from Diabetes Practice Support Pharmacist review project • Agree engagement plan with Xyla facilitators to increase referrals into the NHS Diabetes Prevention Programme (NDPP) • Diabetic foot care primary care education and awareness project – education sessions in practices to commence • Diabetes transformation funds – Specialist Psychology and Type 1 audit roles to be recruited to. • Commence work with Community Champions on Diabetes, Hypertension, and Healthy Living outreach projects. • Planning for post-stroke community support procurement.	• Commence post-stroke community support procurement. • Mobilisation of Spirometry Hublet Following agreement of model of delivery of spirometry in care networks is agreed, staffing, equipment, pathways, contractual and payment mechanisms will have to be put in place to support delivery	• Evaluation of risk stratification and inequalities elements included in 22/23 LTC Contract and development of approach to be embedded in 23/24. • Provider in place for post-stroke community support.	Laurie Sutton-Teague, Vivien Molulu

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

The Partnership leads are Charlotte Painter, Chris Pelham, Anna Hanbury, Ellie Ward, Mags Farley, Mags Shaughnessy Others TBC

City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
5. **AREA OF PRIORITY/ BIG TICKET ITEM** **Discharge** (Cross cutting approach – Tbc) *We are working together as a health and care partnership to ensure that our discharge best meet the needs of our residents.* *We are enabling this through the development of structures, processes and pathways that will support safe, effective, efficient (timely) discharge from hospital.* *Our approach of* - ***A Home first principle*** *is to ensure patients do not stay in hospital bed any longer than necessary* - ***Maximising re-ablement potential*** *is to promote independence*	The outcomes we expect our work on Discharge to drive include • An improvement in health-related quality of life for people with long term conditions • Making sure more people are able to live independently for longer	• Independent review of C&H Discharge pathways (Single Point of Access (DSPA)/ all partners involved in discharge pathways) • Explore opportunities / introduce consistent process & pathways across NEL (e.g. DSPA referral & response standards) • Explore opportunities for development of a range of initiatives to support simple discharges (pathway 0 & 1 discharges – zero/minimal social care needs)	• Development of discharge improvement plan / business case for recurrent funding if required to implement recommendations from the review and initiatives to enhance 7 day discharges. • Modifications to any service specifications as required, following service review. • Implement / embed initiatives identified	• Implementation of improvement plan	Cindy Fischer Mark Watson Simon Cole Mags Shaugnessy
6. **AREA OF PRIORITY/ BIG TICKET ITEM** **Personalised Care (PbP element)** (Cross cutting approach – a,b,c) *Our approach to Personalised care is built around the person and their family - it allows people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences.*	The outcomes we expect our work on Personalised care to drive include • Increased access to wider services • Maintained operating plan trajectory • Increased % of people reporting they feel involved in their own care (GPPS)	• Social Prescribing and Community Connectors Procurement Outcome • Personalised Care element of NHS standard contract developed. This will outline the things we would like contract holders to focus on e.g. referring people to social prescribing when relevant, ensuring all staff have access to personalised care training etc.	• Mobilise new Social Prescribing and Community Navigation service • Delivery Operating Plan metrics for Personalised Care. This is will outline how we measure the success of our Personalised Care approach in practice. E.g. % of people who feel involved in their own care	• Develop a Personalised Care Strategy for System	Eeva Huoviala

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

The Partnership leads are Charlotte Painter, Chris Pelham, Ellie Ward, Anna Hanbury, Chris Lovitt, Mags Farley, Mags Shaughnessy, Others TBC

City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

Cross cutting approaches:

a **=** Ensuring healthy local places	***b*** **=** Joining up local health and care services around residents and families' needs	***c*** **=** Increasing social connection
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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
1' & 2' care interface (Cross cutting approach – a,b,f) *This programme of work focusses on building positive relationships between primary care (GP practices) and secondary care (hospitals) and a joint approach to solving specific areas of difficulty or conflict.*	The outcomes we expect our work on 1' & 2' care interface to drive include • Maintaining positive relationships between primary and secondary care clinicians and staff • High quality referrals (reduced number of d/c after 1st appointment) • Improved management of DNAs leading to reduction in DNAs	• Sign off Consultant to Consultant referral policy at Homerton – to reflect balance of clinical workload and responsibility between primary and secondary care • Set up clinician to clinician meeting to discuss areas of concern and potential solutions • Feedback to Primary Care Leadership Group outcomes of discussions	• Agree focus of audit in primary care – Did Not Attend reviews and Outpatient referrals. • Womens Health programme cross cutting service issue/solution approach	• Tbc	Charlotte Painter; River Calvely, Gary Marlowe
Elective Care recovery (PbP element) (Cross cutting approach – a,b) *We are working with our local Planned Care hospital and community providers to return all services to business as usual and prepare for the long term plan; ensuring primary care and community pathways are optimised and services are transformed to this aim reducing hospital activity and supporting patients earlier in the community.*	The outcome we expect our work in Elective Care recovery to drive is - to restore waiting times for elective care to pre pandemic levels	• Agree clinical lead model for planned care and NEL clinical networks • Mobilisation of Specialist Weight Management Service/Paediatric ENT community services such as the Specialist Weight Management Service providing more focussed support to patients with morbid obesity and providing an Ear, Nose and Throat service in the community for Children aged 5 and over.	• NEL wide procurement of Minor Eye Services and Community ENT/Audiology services ensuring equitable access but continue to meet local needs • Evaluation to decide on full roll out of neighbourhood based gynaecology pilot. This is based in 2 PCNs meeting women's gynaecology needs in primary care, supporting self care and GP education	• Contracting and mobilisation of Community ENT/Audiology and Minor Eye Services. • Roll out of gynaecology pilot (depending on evaluation)	River Calveley
Prevention Priority: Tobacco control (Cross cutting approach –Tbc)		• Tbc	• Tbc	• Tbc	
Prevention Priority: Substance misuse (Cross cutting approach –Tbc)		• Tbc	• Tbc	• Tbc	
Prevention Priority: Sexual health (Cross cutting approach – Tbc)		• Tbc	• Tbc	• Tbc	Chris Lovitt

Strategic Priority: Preventing and improving outcomes for people with long-term health and care needs

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City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Key Milestones 2022 - 2023 Oct -22 to Mar-23	Key Milestones 2023 - 2024 Apr-23 to Mar -24	Leads
ICS-directed transformation area: Continuing healthcare (CHC) (Cross cutting approach – a,b,d)	The outcomes we expect our work on Continuing healthcare to drive include: • Ensuring there is better family experience of CHC process (reduce complaints) • Maintaining / improving adherence to National targets for assessment and reviews to ensure appropriate care	• Transfer CHC team to NEL governance structure • Development of CHC operating model	• Tbc	• Tbc	Diane Jones
ICS-directed transformation area: Cancer (Cross cutting approach – a,b,c)) *Our local cancer work will focus on improving patient experience of cancer services, Personalising care pathways, increasing awareness and improving screening uptake in bowel and cervical cancer.*	The outcomes we expect our work on Continuing healthcare to drive include: • An improved patient experience • An improvement in accurate and timely diagnosis • A reduction in stage of cancer at diagnosis	• Mission Remission Patient Experience Action plan sign off (C+H) • Improve awareness and embed straight to test pathways to help meet the Faster Diagnosis Standard of 28 days from referral to diagnosis. • Delivery Bowel Screening Calling project - Increasing uptake of colorectal cancer screening in Hackney and the City. The target population for this project is the Rising 56's: individuals approaching 56 and therefore eligible for bowel screening, with a particular focus on male and BME communities • Delivery Cervical Cancer Screening project - Increasing uptake of cervical cancer screening in Hackney and the City. The overall aims of the project are: to increase overall uptake of cervical screening by targeting women between the ages of 25 and 49 that identify as South Asian and 'Other' ethnicities that have the lowest uptake rates by recorded ethnicity in City and Hackney and also document reasons for not attendance to inform future interventions. • Approval of revised Bowel Cancer Screening interventions to increase uptake across all PCNs using funding included LTC Contract. We are looking to engage an outside organisation to support practices and undertake more targeted work with hard to reach communities to increase Bowel Cancer screening uptake	• Delivery Bowel Screening Calling Service - increasing uptake of colorectal cancer screening in Hackney and the City • Delivery Cervical Cancer Screening project - increasing uptake of cervical cancer screening in Hackney and the City • Implement actions from mission remission action plan • Implement awareness campaign for straight to test and cancer screening.	• Evaluation of Bowel and Cervical screening inequalities projects targeting the BME and South Asian and other communities respectively	River Calveley, Vivien Molulu

Strategic Priority: Preventing and Improving outcomes for people with long-term health and care needs

The Partnership leads are Charlotte Painter, Chris Pelham, Anna Hanbury, Ellie Ward, Mags Farley, Mags Shaughnessy Others TBC

City and Hackney PbP Programme/s: People with long term health and care needs | Planned Care recovery | Urgent and emergency care and discharge

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2022 - 2024 Transformation Area Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f	The outcomes we expect each action area to drive	Key Milestones 2022 - 2023 July-22 to Sep-22	Oct -22 to Mar-23	2023 - 2024 Apr-23 to Mar -24	Leads
ICS-directed transformation area: Urgent and Emergency Care **(Cross cutting approach – Tbc)** *Our goal for this programme of work is to provide:* - *Resilient responsive emergency services* - *Integrated urgent care - ensuring patients receive the right care first time – as close to home as possible* • *Single point of access to urgent care system* • *Effective assessment and management including onward referral if necessary* • *Robust urgent primary and community provision as alternative to ED –ensure sufficient capacity accessible by all UEC partners* • *Capturing the right data to measuring / monitoring performance and outcomes*	The outcomes we expect our work around Urgent and Emergency Care to drive include: • A reduction in the inappropriate use of the urgent care system – improve management of crises outside of urgent care • An improvement in patient experience of urgent care services • Resident knowledge of services and confidence in using them	• Continued implementation of action plan to reduce Cat 2 ambulance delays – demand management, handover, hospital flow & discharge • 111 IUC service – • clinical review of 111 Clinical Advice Service • Agree 22/23 service model & contract informed by clinical review and rebasing (activity / staffing) exercise • Increasing utilisation of primary and ommunity services to manage patients safely away from hospital • Rollout of worklist approach to direct book into GP practices • Embed new CPCS pathway • *Consider model for optimal system management of urgent primary care (GP, community, 111,UTC)* • (UCR and Virtual Ward programmes) • Release of new UTC standards - review compliance & agree action plan to meet gaps • SDEC • Continued roll out of 111 symptom based pathways into SDEC • Work with 111 and DoS team to identify opportunity to increase referrals • Direct conveyance into medical pathways • REACH development steering group to review current REACH (model & outcomes) – consider opportunities to develop to maximise benefit across NEL • UEC data & performance standards - establish NEL programme governance to manage review and implantation of emergency care data set (ECDS) and new bundle of performance measures *Establish C&H UEC steering / management group –* - *Monitor activity & performance UEC & discharge* - *Agree C&H position / response to NEL directed transformation areas* - *Identify local UEC improvement opportunities to support and supplement NEL plan* - *Develop / agree C&H UEC improvement plan (combined NEL & C&H priorities) and maintain oversight of delivery*	• Agree & procure new model for IUC to be commissioned when existing contract expires August 2023 • SDEC – continue roll out of agreed pathways & initiatives to increase utilisation • Consider opportunity to expand scope of SDEC including frailty pathways • Integrate SDEC with other key elements of enhanced community response – UCR and emerging virtual ward provision • REACH – agree and implement REACH development plan • Implementation of ECDS & New UEC performance measures • *Implementation of additional C&H improvement initiates identified*	• TBC	Anna Hanbury Mags Shaughnessy Richard Bull BC
Key actions to address inequalities: • Outlined throughout and embedded in the key actions					

Strategic Priority: The City and Hackney Place Based Neighbourhoods Programme

***Addressing Cross cutting approaches**:*
a = Ensuring healthy local places;
b = Joining up local health and care services around residents and families' needs;
c = Increasing social connection;
d = Supporting greater financial wellbeing,
e = Taking effective action to address racism and other discrimination; f = Supporting the health and care workforce

Partnership Leads *(Tbc)* : Sadie King

The City and Hackney Place Based Neighbourhoods Programme

The Partnership leads are Sadie King (Programme Lead) , Aimee Henderson (Clinical Lead)

Cross cutting approaches:			
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2022 - 2024 Transformation Area **Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f**	**The outcomes we expect each action area to drive**	**Key Milestones** 2022 - 2023 July-22 to Sep-22	Oct -22 to Mar-23	2023 - 2024	**Leads (TBC)**
Neighbourhoods Priority 1: Addressing Rising Need (cross cutting: a, b, c, d)	Outcomes framework due July / August 2022	• Phase 2 of Co designing an anticipatory care pathway • Children's services anticipatory care pathway pilot • Supporting the Development of the community navigation system aligned to the neighbourhood footprint : • The recommissioning of the Social Prescribing & Community Navigation service • Production of guide and mapping of community navigation system. • Review pilots on community navigation.	• Phase 3 Embedding in each neighbourhood an anticipatory care pathway • Children' services anticipatory care pathway pilot evaluation • Produce strategy and refresh Toc on community navigation work. • Roll out pilots on how community navigators work with PCNs across all neighbourhoods	Evaluation of anticipatory care pathway and review Community navigation action from strategy tbc	Sophie Green Neighbourhoods Programme Manager Dr Aimee Henderson Clinical Lead for Neighbourhoods Annabelle Burns Head of Integration Homerton Healthcare NHS Foundation Trust Mark Young Neighbourhoods Programme Manager Dr Tehseen Khan GP at Spring Hill Practice Joint Clinical Director Springfield Park & Woodberry Wetlands Sana Mufti Specialist Registrar in Geriatric and Stroke Medicine Jane Cadwell Age UK East London
Neighbourhoods Priority 2: Driving and improving multidisciplinary teams (cross cutting: a, b, f)	Outcomes framework due July / August 2022	• Aligning Mental Health teams with MDMs	• MDMS working with anticipatory care pathway effectively	• Voluntary sector participation (referral pathway and provider) in MDMs established	Sophie Green Programme Manager Neighbourhoods Programme Dr Aimee Henderson Clinical Lead for Neighbourhoods

The City and Hackney Place Based Neighbourhoods Programme

The Partnership leads are | **Sadie King (Programme Lead) , Aimee Henderson (Clinical Lead)**

Cross cutting approaches:			
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2022 - 2024 Transformation Area **Including how Programme activity addresses cross cutting approaches using a,b,c,d,e,f**	**The outcomes we expect each action area to drive**	**Key Milestones**			**Leads TBC**
		2022 - 2023		**2023 - 2024**	
		July-22 to Sep-22	Oct -22 to Mar-23		
Neighbourhoods Priority 3: Supporting the neighbourhoods workforce (Cross cutting: e, f)	Outcomes framework due July / August 2022	• OD plan, Theory of change and outcomes framework co-produced and agreed	• OD pilot in anticipatory care pathway complete and proposals for 2023 - 24	Deliver Phase 1 of a system wide OD programme	Sadie King Neighbourhoods Programme lead Ilona Principal Head of Adult Social Care at London Borough of Hackney Laura McMurray Head of QI Homerton Healthcare NHS Foundation Trust Mohammed Mansour, Development Manager, Hackney CVS Sonia Khan Head of Policy and Strategic Delivery London Borough of Hackney
Neighbourhoods Priority 4: Embedding a structure for resident involvement in neighbourhood decision making (a, b, c)	Outcomes framework due July / August 2022	• Community Forums new staff recruited and systems established. • Aligning the City and Hackney review of resident involvement and the PCN DES on Resident engagement with the models of resident engagement. Built into new recurrent funding grants • Launch of Neighbourhood website	• Community Forums operational • Local agreements on resident involvement and decision making partnerships agreed.	Embedding of Neighbourhood partnership arrangement s with clear pathways of communication with the new Community Forums	Tony Wong - Chief Executive Officer - Hackney CVS Susan Masters Director, Health Transformation, Policy and Neighbourhoods, Hackney CVS Sabrina Jantuah Neighbourhoods community development manager Hackney Healthwatch
Key actions to address inequalities:	Outcomes framework due July / August 2022	• Evaluation of Neighbourhoods commissioned with outcome framework leading to addressing inequalities short, medium and long term outcomes (ToC and Framework out in July/August) • All Neighbourhoods projects having EIAs produced with action plans going forward.	• Evaluation of Neighbourhoods produces regular updates on how inequalities are being addressed through the model. • Progress of PCN Inequalities Delivery Groups to action plans	A Neighbourhoods inequality action plan is regular monitored and publically available.	Dr Anu Kuma Lead for Patient Involvement and Inequalities for City and Hackney Sadie King Neighbourhoods Programme Lead Dr. Gopal Mehta Clinical Director, London Fields Primary Care Network GP Confederation GP Lead for South West of Hackney & The City of London Peter Merrifield CEO SWIM