Appendix A – Summary of 19/20 System Commissioning Intentions

Unplanned Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient, resident and clinical feedback and engagement
Discharge	Deliver the Discharge to Assess (D2A) Pilot Recommission the Integrated Independence Team (IIT) contract, including sourcing suitable space for 4 Intermediate care beds Work with Age UK to expand the Take Home and Settle service	HUH, LBH, Age UK	• Reduction of DToCs (Delayed Transfers of Care) across the system • Reduction in excess bed days • Better quality of assessment and improved patient access • Savings related to hospital bed usage (£) • Patients will benefit from an intermediate bed service closer to home and which suits local need • The Take Home and Settle Service assists patients who have just been discharged form hospital - patients will have a smoother transition from hospital 'back home' • Savings related to reduced hospital bed usage (£)	Service user representatives are part of the Discharge Steering Group A discharge co-production event took place in October 2018 *Direct feedback from patients:* 'Cross borough hospital discharge needs to be better coordinated' 'Hospital discharge plans need to be made in partnership with the person from the start' 'Need step-down and step-up beds in Hackney'

Urgent Care	Deliver a new, more integrated GP Out of Hours service which integrates our current OoH service with the Primary Urgent Care Centre (PUCC) Improve our falls response and prevention services	HUH, GPC, CHUHSE, OTAGO	• Improved working between primary and secondary care, • Reduce % of London Ambulance Service calls resulting in a conveyance • Improve % A&E attendances diverted into PUCC • Residents vulnerable to falling can access a range of services and can access a less fragmented offer • Reduce overall costs to the system from falls (£) • Support managing demand on City and Hackney emergency services (£)	Integrated GP out of hours service user engagement event held in May – 32 residents attended. A service user representative is part of the Urgent Care Reference Group The Falls Prevention Service was taken to our Patient User Experience Group in with July 2018 *Direct feedback from patients:* ‘111 call handlers need to be trained and able to identify when someone has urgent need. City residents shouldn’t be automatically sent to the Homerton when other hospitals are closer’ Feedback from our Clinicians: Queries around what the GP Out of Hours service was likely to look like Feedback around the type of patients being treated by the

				Ambulatory Medical Unit (HAMU) for which we are being charged tariff costs (e.g. vitamin B12 injection)
Neighbourhoods	Continue to progress the development and delivery of the City and Hackney Neighbourhoods Model	GP Confed Hackney CVS Homerton ELFT	• Reduction in duplication of effort/resources/time • Reducing emergency attendances and admissions • Improved patient reported measures • Improvement in recruitment and retention • Support system sustainability (£) • Make services more responsive, accessible, and joined up for residents	Neighbourhood patient panel convened, large-scale engagement underway in one of the neighbourhoods *Direct feedback from patients:* 'Personalisation is essential in the new Neighbourhoods care model'
End of Life Care	Commission a City and Hackney Hospice at Home service as a one year pilot	St Joseph's Hospice	• Patients will be able to access a person centred and sensitive service, which will specialise in a range of areas specific to end of life care including pain management and family/carer support • We expect the service to lead to a reduction in hospital admissions	The proposed model has been discussed with service user representatives at the Unplanned Care Board Further work is planned to involve service user representative in the model
Mental Health	Improve our offer for patients with Dementia including: The Dementia Memory Clinic (ELFT) and Dementia Navigation and Support Service (Alzheimer's Society)	ELFT Alzheimer's Society HUHFT	• Greater integrated alignment in Mental Health • Dementia Navigation and Support Service: expanded • Savings related to a reduction in hospital admissions inc. bed usage and A&E attendances (£)	We have involved users in the design of the Dementia Memory Clinic model through the psychological therapies alliance and

	Pilot a single integrated pathway for frequent attenders including those patients who use A&E, 111 and London Ambulance Service (LAS) frequently Use the outcomes of the Health Based Places of Safety (HBPOoS) options appraisal to devise a new staffing model for ELFTs HBPoS sites Review inpatient usage against recent increased investment into crisis services to explore optimum number and location of beds Pilot a Mental Health Neighbourhood Blueprint in 2019/20		• Meeting NHSE Dementia Diagnosis targets and centralised dementia register • Better sharing and co-ordination of care plans across organisations • Reduction in frequent attendance 6 months prior to & 6 months after for A&E, 111 and LAS and reduction in costs associated with frequent attending • Better quality built environments in terms of patient safety, privacy and dignity • Better trained staff with a broader range of skills • Improved understand of system requirements	the mental health voices advocacy project.

Planned Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient and resident feedback
Outpatients Transformation	Continue our Outpatients Transformation Programme [until March 2020]	HUHFT	• Better local support to allow patients to manage their own care • Services that can be accessed locally • Reviewing specialty pathways with secondary care for more mental health support • Reduce the number of multiple appointments spread over different days to avoid wasting time • Improve listening to patient and support • Improve equity of access • Preventing unwarranted first attendance	Local Healthwatch organisations are engaging patients on outpatient service and specialty reviews will include an ongoing dialogue with any proposed changes and what specific patients' needs must be addressed. *Direct feedback from patients:* 'Patient choice is essential. Outpatients appointments structure and communications need to be individualised and personalised' 'Electronic and text options should be available for appointment confirmations and results but with a choice to receive letters'
Learning Disability Transformation	Ensure that the whole population of people with Learning Disabilities have access to the same opportunities as the rest of the population	Various	• Strategy for people with Learning Disabilities across the borough identifying approach to universal and specialist services	Quarterly partnership forum with service users

	Continue to develop and deliver the Integrated Learning Disabilities Service (ILDS) model of integrated working		• Service specification with identified outcomes for ILDS specialist service • New integrated ILDS with clear pathways in place including: better accommodation, local understanding of the health needs for people with LD, reduction in health inequalities, better day services, smoother transitions, improved crisis support, improved support for those receiving long term care • Efficiencies will be delivered through integrated working (£)	Annual 'Big Do' for service users – with a range of workshops to input into service design *Direct feedback from patients:* 'Need better support for adults with learning disabilities in hospital – should always be given advocate'
Continuing Healthcare (CHC)	Extend our CHC domiciliary care and nursing home providers with a 2-year extension We are also considering whether to join the Domiciliary Care AQP contract for 2019/20 We are reviewing the options for - Provision of a CHC brokerage function to support the Homerton CHC team	Dom Care and Nursing Home Providers, HUHFT and LBH	• Improvements to the CHC domiciliary care and nursing home contact through reviewing the service specification and the KPIs in the contract • Reduction in individual procurement costs • Capitalise on synergies to work together around contracts, quality monitoring, service user safety, punctuality of care and also brokerage of packages of care • Creation of a more responsive, flexible and cost effective service • CHC bed base will help ensure that patients can be discharged from hospital more quickly once medical needs have been met	Intent to recruit service user and family/carer representatives to adopt a coproduction approach to CHC services

	- Delivery of care within people's homes overnight to residents with CHC and fast track requirements Residential Placement Options – as part of our work on pooled budgets we intend to review commissioning arrangements for local care homes bed		• Will allow greater flexibility for placements	
Cancer	Continue to deliver cancer targets with our providers Recognise living with cancer as a long term condition Better recognition of those requiring 2 week colorectal cancer referral Commission PSA monitoring for patients with stable prostate cancer in primary care	HUHFT, Barts Health, UCLH, Primary Care	• Work towards meeting the following targets: specialist within 7 days, referral-to-treatment in 62 day target and ITT to be completed in 38 days • Provide more ongoing support to patients and families • The service change will deliver shared care arrangements that ensure the patient receives holistic care closer to home at their local GP Practice. It will release capacity in secondary care and will generate a financial saving.	Patient representative sits on the Planned Care Workstream

Service Development	Develop an online tool for patients which will enable them to self-refer directly to the Physiotherapy Service Commission the current Minor Eye Condition service to provide: a specialist referral review, advice on GP treatment, and referrals to the Minor Eye Condition service and to secondary care Work with colleagues at LBH and CoLC to create a Women's Health Community Service Upskill practices nurses so they can better support parents of children with eczema Undertake review of the Teledermatology Service, due to	Community locomotor Service and GP Primary Care MEH & HUHFT, HUHFT, Community Pharmacists	• Patients will be able to self-refer and use an online service to receive advice and guidance • Service to encompass: Gynae, Pelvic Floor Continence, Linked Sexual health, Fertility, Contraception, Breast and Menopause leading to more integrated working arrangements between professionals • Reduction in time spent by clinicians managing low level eczema management.	Utility in signposting patients who call surgeries to leaflets and YouTube links to support them – and the Physio-self referral service Feedback from our Clinicians: Query around Womens Pathways – potential for the Community Health Services to be the enabler

	start in 2018/19 and its impact on community services Work with the Prevention Workstream to develop and implement an Obesity Pathway for City and Hackney Work with the Prevention Workstream to review the post stroke rehabilitation pathway and implement recommendations from the Type 2 Diabetes Healthcare Needs Assessment Develop a local a Discharge to Pharmacy service where a discharged patient cohort are referred to a pharmacist in primary care to support medicines use.		• Patients are effectively supported in the community after having a stroke • Services are aligned with models of best practice and are providing optimal care for people living with type 2 diabetes in City and Hackney • Improve the discharge process in secondary care • Reduce delayed discharge by enabling pharmaceutical input • Patients receive the correct medicines on discharge and are able to use their medicines (e.g. inhalers), after discharge • Reduce hospital admissions and readmissions • Minimise risk of errors [e.g. patients being supplied medicines which were stopped during their inpatient stay]	Patient Representative (a member of the HUHFT Patient Safety Committee) is a member of the local discharge to Pharmacy steering group
Personal Health Budgets	We will extend our PHB offer to all CHC eligible patients receiving care at home The psychological Therapy and Wellbeing Alliance will pilot PHBs	Network VSOs, ELFT HUHFT	• PHB give service users greater control and choice over the care they receive. Care and support plans are more person centred and clearly outline costs of care.	Through Service User Mental Health Coordinating Committee reps

	for patients frequently attending A&E due to Mental Health concerns The Homerton Hospital Wheelchair service will pilot a PHB offer in quarter 4 of 2018-19 with a full rollout by 2019		• Plans to work with mental health service users – which will provide greater support for people with more severe mental health problems.	Mental Health Voice Service User group consulted
Mental Health	Develop more integrated pathways across HUH psychological therapies to link together IAPT interventions and HMP Create a secondary care psychological therapies offer	IAPT (HUH main provider), ELFT, Network VSOs	• Greater integrated alignment in Mental Health • Addressing the current unmet MH needs for people with LTCs in line with national strategy. • Improved contractual performance in relation to the delivery of recovery and clinical improvement • Improving the breadth of offer to patients • Increase cost / effectiveness (£) • Elimination of backlog waiting lists • Regular reporting of activity and outcomes • Greater availability of open access psychological support for crisis • Clear structures and pathways that support local integrated care strategies • A joined up health and local authority approach to mental health	Through Service User Mental Health Coordinating Committee reps Mental Health Voice Service User group

	Review existing mental health accommodation contracts Develop a Primary Care Liaison Service that links with emerging structures such as Primary care Neighbourhoods and population mental health issues		accommodation inc. increased use of floating support • Improved value for money (£) • Improved primary care integration in Neighbourhoods	
Prescribing	Continue to deliver a programme of Prescribing activities covering: • Clinical / Prescribing audits • Medication reviews • Quality improvement • Safety Antimicrobial Stewardship Biosimilar medicine optimisation	GPC, GP Practices , HUHFT	• Support safer prescribing and use of medication • Support a reduction in medicines wastage • Improve patients' understanding of their medication • Improve communication, relating to medicines & prescribing, across the interface and between professionals • Share learning & good practice Continue with activities including training and auditing – to ensure City & Hackney CCG continues to reduce inappropriate prescribing and use of antibiotics • Increase the uptake of biosimilar medicines by HUHFT in line with NHSE's prioritisation of	This has been consulted on at various patient and service user events; consistent feedback from patients around greater education on their medication to provide them with imported insight Prescribing Committee has a patient and public representative on the committee; all work plans have been reviewed by this group.

	Anticoagulation		implementing best value biological medicines. • Increase the number of patients able to access anticoagulants in primary care • Work to review adherence to newer anticoagulation medicines	

Prevention Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient and resident feedback
Support early identification (of risk factors) and early diagnosis of Long term Conditions	Update the Long Term Conditions (LTC) contract, including updating contract KPIs, and integrating the NHS Health Check into the LTC contract Embed the following 2018/19 (acute) CQUIN targets as service KPIs: preventing ill health by risky behaviours– alcohol and tobacco (screening advice / support & referral)	GP Confed, HUHFT	• Better incentivise early detection of conditions and support the effective management of long-term conditions in primary care • More patients assessed for risk of CVD • Increase in number of people receiving preventative advice/ services • Increase in number of patients receiving evidence-based support to manage their health • Patients supported to quit smoking and/or access support to reduce harmful levels of drinking. • Reduce the health harms from both of these risky behaviours	Patient Public Involvement (PPI) Committee Co-production events planned for the Making Every Contact Count Programme *Direct feedback from patients*: ‘Need more information on COPD including in other languages’

				'Need community space in the City where can run peer group activities e.g. for those with type 2 diabetes offering drop-in, cooking/diet advice'
Enable people to live healthy lives and manage their own health	Re-commission Social Prescribing service to better integrate with other care navigation services in City and Hackney, including Health Coaches (commissioned by LBH Public Health)	Family Action	• Residents have access to information, advice and support to help them live healthier lives • Patients are better-equipped to manage their own health	Commissioning intentions engagement event *Direct feedback from patients*: 'Need access to affordable exercise like yoga, and healthy eating information and advice' 'Air pollution is a problem. People should be encouraged to use electrical cars and children in the City should be given pollution masks' 'Neaman Practice should offer social prescribing but needs to be community/voluntary activities in the City'
Mental Health	Embed the following 2017-19 (mental health) CQUIN targets as service KPIs: • Cardio metabolic assessment and treatment for patients with psychoses	ELFT, WDP	• Patients with psychoses will be supported to lose weight and quit smoking – with significant long-term health benefits • More mental health inpatients will be supported to quit smoking and/or	Mental Health Advocacy Group (via the Mental Health Coordination Committee)

	(EIP BMI outcome indicator and EIP smoking cessation outcome indicator) • Preventing ill health by risky behaviours– alcohol and tobacco (screening advice / support & referral) Improve access to mental health support services for people with substance misuse [part of a broader strategy to review substance misuse service] Develop an integrated approach to employment support for people with mental health problems		access support to reduce harmful levels of drinking; this will reduce the health harms from both of these risky behaviours • Reduced dosage of anti-psychotic drugs (e.g. clozapine) in smokers who quit • Improved recovery rates and mental health outcomes for people with substance misuse problems • Improved access to employment, with significant associated benefits for health and wellbeing and supporting recovery.	Hackney's Supported Employment Network

Children, Young People and Maternity (CYPM) Care Workstream

Transformation Area	Commissioning Intention 19/20	Provider	Expected outcomes, including patient and cost savings	Patient and resident feedback
Maternity Services	Deliver improvements to work towards an 'Outstanding' CQC rating (now 'Good')	HUHFT	• Improve the overall governance and safety of the service • Ensure the women accessing services at the Homerton are receiving optimal safe and quality care	*Direct feedback from patients:* 'More health and mental health support for mothers after giving birth'

	Reduce infant mortality and avoidable admissions to NICU Explore carrying out clinical audits into deliveries with complications and emergency caesareans Continue to promote the offer of the flu vaccination and pertussis to expectant mothers Increase continuity of care in line with NHSE recommendations Continue to deliver a robust perinatal mental health offer Continue to support women with Long Term Conditions (LTC) to		• All maternity and neonatal services to work together to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so. • Ensure that maternity risks are identified and actioned early • Increased numbers of women with flu and pertussis vaccinations • 20% of City and Hackney women delivering at HUH will have continuity of carer • Women planning a pregnancy including those with LTC are informed of ways to improve their	Feedback from our Clinicians: Query around the Homerton Maternity unit staffing – confirmed that service is currently at full capacity

	have safer healthier pregnancies and deliveries		health and that of their baby during pregnancy • There is support available with clear pathways for women with LTC during pregnancy	
Children, Young People and Maternity	Develop a high quality acute and community paediatric services including new baby clinics and la health offer for Looked After Children Agree tariffs and explore improving pathways for critical care To develop a clear offer for children in need of continuing healthcare and personal health budgets Develop a specialist epilepsy nurse offer, alongside a new respiratory specialist nurse offer, embedded across A&E and Primary Care	Range of providers including: HUFT, VCS, GP Confed, Primary care , Whittington Health, LBH CYPS	• More effective pathways for LAC through health, particularly for those CYP with complex health needs, mental health needs and challenging behaviour needs • Improved LAC service including monitoring of LAC performance and staffing issues • Enhance joint working between community paeds and primary care, recognising the trainee resource that can support capacity issues in primary care and offer optimised training opportunities. • Support reductions in unplanned asthma attendances • Clarify service provision and funding arrangements for SEND children and their families	A full engagement plan is being rolled out as part of the design of the new LAC health service. A SEND A co-production and engagement plan is being developed currently with our parent representatives *Direct feedback from patients:* 'Better assessment and support for young children with autism'

	Improve local pathways for children with Special Educational Needs and Disabilities Design and implement a new tier 2 and 3 audiology service Improve care pathways and information sharing across primary care to improve diabetes care Improve uptake of immunisations		• Increased access to early health support for children with SEND	
Mental Health	Continue to ensure we have a system that meets the needs of every child in City and Hackney Increase CAMHS access rates: we expect access rates to increase 35% by 2020/21 (an extra 70,000 children and young people nationally)	HUHFT, ELFT	• CAMHS support in all schools by 2020 • Assessment target of 2,068 in 2019/20 • Meeting the national target of increasing CAMHS access rates • Increased diagnosis (linked to increased investment) • Clearer pathways for residents and non-residents • Improved access to support for crisis • Improved outcomes for those transitioning to adult mental health services	Young Hackney has delivered a children and Young Peoples consultation to inform direction and development of the CAMHS transformation plans. *Direct feedback from patients:* 'Improve mental health not just for children with serious need but overall'

	Support the development of the Phase 3 CAMHS Transformation Plan focussing on schools, transition, parenting and crisis		• Reduced waiting times to entering treatment within 6 weeks by Q3, 18/19 • Extended hours of Paediatric Psychiatric liaison in A&E to 10pm • Enhanced eating disorders service • Improved neurodevelopmental pathways including increase funding for Autism diagnosis and aftercare	'Need more information in schools around mental health, young carers and what is inappropriate caring, sexual assault and safe relationships, healthy eating and cooking, general health, smoking, how to protect yourself, dental care' 'Need to fund mental health therapists in City schools'