Journey to a New Health and Care System

ICS Chairs and SROs

24 April 2020

Revised Following Meeting

NHS England and NHS Improvement

Context

- *Our common purpose remains to be the world's healthiest global city with the best health and care system*

- *Prior to the pandemic, the health and care system in London faced significant operational, workforce and estates pressures in acute, elective, primary care, mental health and community based care*

- *Integrated Care Systems analysed their population's health needs and prepared detailed plans to meet them through delivery of the NHS Long Term Plan*

- *Covid 19 brings new challenges to the health and care system and at the time of writing the virus will continue to circulate in the community and create additional demand requiring a range of public health measures to contain spread*

- *In the initial phases of the pandemic, the rate of spread in London was faster than the rest of the country. The NHS and local government moved rapidly to expand critical care capacity, distribute supplies, implement new models of care and support for the most vulnerable e.g. care home residents, homeless people*

- *However, as we move into a period in which Covid continues to circulate and remains a threat, it is clear that to be the healthiest global city, we will need to fundamentally shift the way we deliver health and care – over and above those that we planned in the London Vision and our ICS plans - if we are to control the spread of Covid 19, limit its impact, address inequalities and the mismatch between need, demand and supply which existed prior to the pandemic*

Summary

1. Clarity from the outset about what success will look like (**eight tests**)

2. ICS the level at which change will be designed and delivered; London-level focussed on creating the conditions for ICS success and on managing pan-ICS assets and capabilities

3. Expectations for each ICS's programme of action, consistent with a big step forward towards the London Vision (**twelve expectations**)

4. **Three** phases to the changes over the next 18 months

5. Our eyes open to the risks of making change happen in an emergency (**five risks**)

1. The 8 Tests We Must Meet

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

2. The ICS as the Key Level

- The ICS is the primary level at which the new health and care system will be designed and delivered

- Assumptions:
  - The executive and clinical leadership teams who have worked together during the pandemic response to date will be the same teams to design and drive forward the new health and care system
  - Change will be provider-led

- Institution-level recovery programmes will need to complement ICS work

- London will focus on setting the conditions for the ICS's to succeed
  - Setting standards (e.g., clinical standards)
  - Convening, championing, identifying, evaluating and spreading good practice
  - Providing input on cross-cutting areas such as workforce and digital to help unblock
  - Coordinating London-wide pathways in specialist services
  - Managing pan-London assets such as the Nightingale Hospital
  - Important role in fending off unhelpful distractions

- To be effective in helping ICS's, London requires some clear approval points:
  - Catalogue of changes made to date; reversal requires London approval
  - ICS programmes of action versus pan-ICS expectations
  - Capital

3. London Vision the Touchstone (1)

	People, places and partnerships to support wellbeing and self-care	Integration to provide joined-up community-based services	Collaboration to sustain high-quality specialist networks
Start well 	Our environment, schools and communities promote and nurture the health and well being of all children and families	Schools and health and care services work together to provide a seamless service and equip families and children with tools to manage their own health	Children and young people have access to high quality specialist care, with safe and supported transitions to adult services
Live well 	Our environments and local communities help us avoid unhealthy habits and eliminate homelessness and any stigma surrounding mental health	Early support for health issues is consistently available and there is true parity of esteem between physical and mental health	Londoner's have access to high quality 24/7 emergency mental and physical health care with care plans in place for on-going support
Age well 	Londoners are supported to manage their long term conditions and maintain independence within their community	As people grow older they are supported in their community with seamless care between organisations	Hospital care is consistent, of high quality and safe and ensures Londoner's can get in and out of hospital as fast as they can

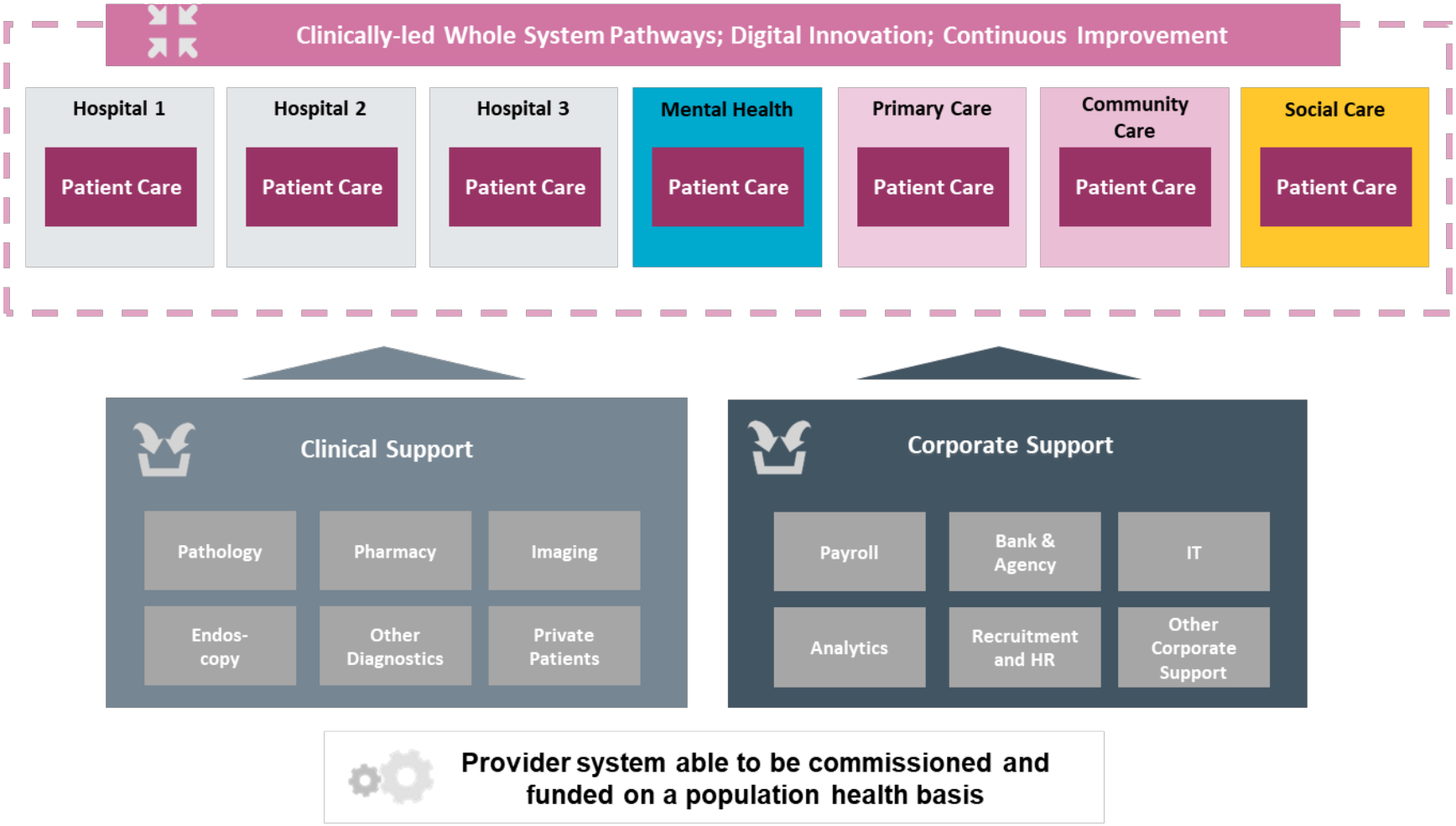
Enabled by

- Ensuring Londoners are engaged in their own health 
- Connecting London's health and care providers 
- Delivering London's workforce 
- Transforming London's estate 

3. London Vision the Touchstone (2)

Neighbourhoods 30,000-50,000 population		• 203 Primary Care Networks with expanded neighbourhood teams • Integration of community-based care services
Place / borough 250,000-300,000 population		• Joint working across NHS and London Boroughs • Focus on population health and inequalities • Providers collaborating to coordinate services
Sub-regional system STP/ICS covering 1.3m-2.1m population		• A single clinical commissioning group for each STP, with a partnership board • Collaboration between acute care providers • Delegation of specialised budgets and provision
London regional 8.9m population		• Action on pan-London issues, overseen by the London Health Board • Creating the conditions for local integration and local autonomy with revised process of oversight and assurance

3. London Vision the Touchstone (3)



3. ICS Action Programmes: 12 Expectations

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

How London Will Support the ICS's

Each ICS delivering a programme of action to meet the 8 tests

1. Covid Treatment Infrastructure
2. Non-Covid Urgent Care
3. Elective Care
4. Public Health Burden of Pandemic Response
5. Staff and Carer Wellbeing
6. Innovation
7. Equality
8. The New Health & Care Landscape

Capacity Planning and Role of Nightingale (Paul Bennett)

Kings Fund

BCG

Specialist Services (Mark Turner)

London Workforce, Innovation and Staff Wellbeing (Ben Morrin)

Digital, Data and Analytics (Vin Diwakar)

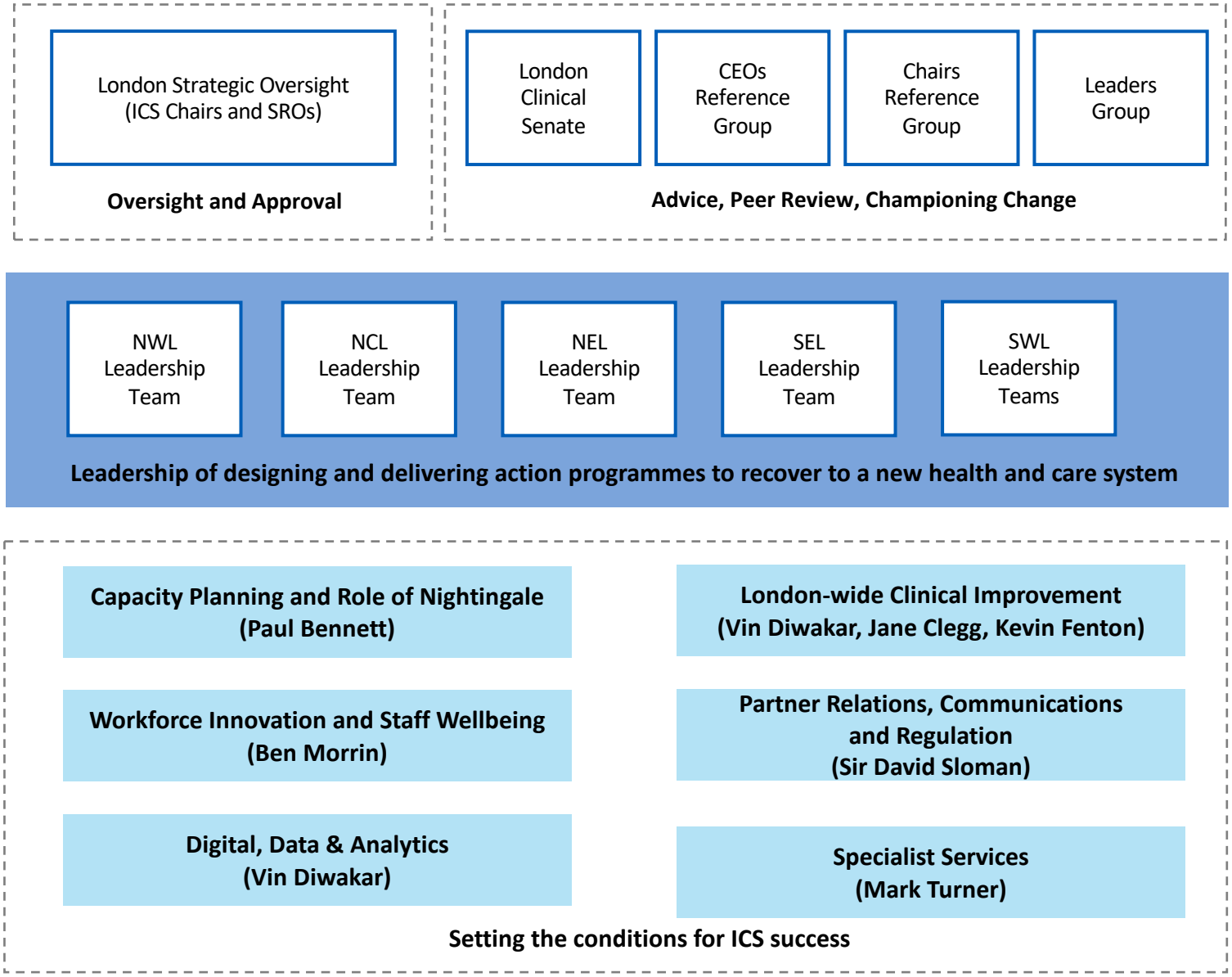
AHSCs

London-wide Continuous Improvement in Clinical Outcomes, Unwarranted Variation and Health Inequalities (Vin Diwakar, Jane Clegg, Kevin Fenton)

Partner Relations, Communications and Regulation/"Preserving ICS "Agency" (Sir David Sloman)

Support

Four Sets of Roles



4. Likely 3 Phases

12-15 months?

Action Programmes

- Reconfigure services to meet the immediate Covid, non Covid and elective need
- Do so by meeting the 12 expectations in a way that best fits each ICS
- Iterate through QI cycles of change, assessment and adjustment
- Include public and stakeholders in the process within the constraints of an emergency

3-6 months?

Transition

- Evaluate the performance of the changes made
- Deliberate with stakeholders and seek public consent for the shape of the new health and care system
- Adjust to reflect input
- Design governance needed for phase 3

From Nov 2021?

The New Health and Care System for London

- Put in place the new health and social care system
- Implement new steady state governance structures
- On-going delivery, assessment and refinement

Early Part of Phase 1

24th April

Guidance (today)

- The 7 tests
- The 12 expectations
- Capacity planning assumptions

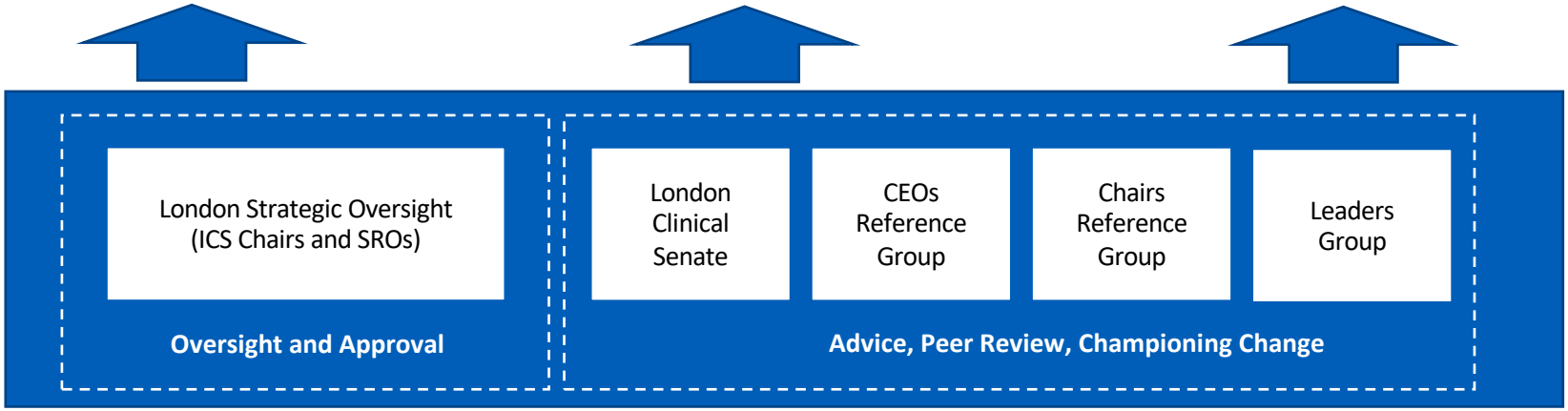
Early May

ICS Proposed Programmes of Action vs the 12

- Leadership team for delivery
- Catalogue of changes made
- Programme of action

From June onwards

Delivery & On going Evaluation and Iteration



5. Risks and Initial Thinking on Responses

1. Reversion to the priorities, approaches, structures and behaviours of the past, particularly given the urgency of dealing with the trio of covid need, urgent non covid need and elective backlog; financial constraints return and undermine freedom to act at pace	• Critical that London enables a continuation of the new culture of pace, permission and space for clinical leaders to have freedom to act during this process; accepting a different kind of risk appetite than the one we are used to • Specific worksteam at London level to ensure ICS "agency" is protected
2. Too strong a gravity towards optimising from an institution by institution point of view; particularly because governance arrangements at ICS level not fully developed or embedded	• ICS the key level at which change will be led and managed • ICS teams to build on effective partnership working during the pandemic response to date; maintaining the same teams wherever possible • London approval needed to unfreeze changes made to date in order to ensure alignment with ICS agenda
3. Too much focus on acute sector and the NHS and too little on primary, community and mental health and the social care sector; particularly because of greater resources, infrastructure and critical mass	• Expectation that the shift in power and resources will be as per London Vision i.e., a radical shift away from hospital care • Freedom to ICS's to lead on primary, community and mental health • LA engagement at all levels especially in expectations 4, 5, 6 & 7
4. Lack of consent and engagement due to emergency action as a level 4 incident	• Previously consulted on proposals such as London Vision to act as major touchstones during phase 1 • Patient and stakeholders must be engaged in deliberations in new and agile ways from the outset; and transparency the core principle • Major focus of phase 2 prior to step-down to a new normal will be to be clear on the new health and care system & adjust according to input
5. Insufficient evidence and learning, course correction and iteration of the new models of care that have been put in place	• Need to build in evaluation as we go during phase 1 • Role for qualified outsiders such as the London AHSNs and The Kings Fund (not "marking our own homework")