Journey to a New Health and Care System

1 May 2020

NHS England and NHS Improvement

Summary

1. The **London Vision** remains the touchstone for the integrated health and care system we will deliver

2. However, there is a new public safety imperative: to urgently put in place **world-class infection prevention and control** practices to be able to simultaneously deal with on-going covid and non-covid needs

3. We will also need to substantially increase our focus on ensuring **equity** for all Londoners, fast-paced **engagement** and **evidence-based learning** as we go

4. The **ICS leadership team** will be the level at which change will be designed and delivered; London-level work will be highly targeted to create the conditions for ICS success and to manage pan-ICS assets and capabilities

5. We will manage decision-making through **peer review and challenge** of the ICS leadership teams

6. This will be based on meeting our pre-agreed common purpose expressed as **12 expectations** for what will be included in each ICS action programme and **8 outcome tests** for what will be achieved by it

7. We will need to navigate **five risks** to making change happen in an emergency

London Vision the Touchstone

- The London Vision represents the agreed direction of travel for London in meeting the NHS Long Term Plan
- It was endorsed by all provider and commissioner boards, the Major and GLA and PHE
- ICS's then analysed their population's health needs and prepared detailed plans to meet them consistent with the London Vision and the NHS Long-Term Plan
- Many aspects of the London Vision and those ICS plans are highly relevant to the urgent current requirements for keeping the public safe and supporting shielded patients, for example, out of hospital care models, the emphasis on self care and borough-based approaches to prevention and the management of long-term conditions
- 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 a **further radical shift** in 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

Working in New Ways

Equity

- We know that there are profound inequities in healthcare access and outcomes reflecting wider determinants of inequality; addressing these must be central to how we make change happen
- People from BAME backgrounds have been disproportionately affected by Covid19 and likewise been disproportionately represented amongst those NHS and social care workers who have lost their lives
- Some of the changes made to deal with Covid19 may have created additional issues for those with the worst access and outcomes (e.g., virtual?)

Engagement

- Our traditional approach to public engagement via formal consultation is unsuited to either action at pace to meet urgent need or indeed to effective engagement with the communities we need to reach
- We will need new innovative and agile approaches to including patients, public and stakeholders in our deliberations
- Transparency about our objectives, action programmes and their rationale will be essential

Evidence and QI

- We will need evidence on which to base assessment, learning and course correction as ICS programmes of change are put in place
- There is a tole for qualified outsiders at ICS level such as the London AHSN/Cs and The Kings Fund and others to help us in this to avoid “marking our own homework”
- The operating assumption is that ICS’s will be using the core disciplines and philosophy of continuous improvement, in particular iterative change based on learning

ICS Action Programmes: 12 Expectations

Meeting Urgent Public Safety Needs

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: self care, primary care, outpatients, diagnostics, 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 triaged 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. Further consolidation and strengthening of specialist services especially where this supports 1 above

Operating More Effectively as an ICS

8. New integrated workforce and volunteer models and new incentives to drive the behaviours needed to deliver these new models of care

9. A single, more resilient ICS-level platform for corporate support services, further consolidation and sharing of clinical support services and further alignment and joining together of institutions within the ICS

Working in a New Way

10. Disproportionate focus and resources for those with the worst access and outcomes

11. A new approach to consent through systematic deliberative public engagement e.g. citizens juries

12. Evaluation, learning and course correction as we go

ICS Action Programmes: 8 Tests

Meet patient needs			Address new priorities		Reset to a better health & care system		
1. Covid Treatment Infrastructure	2. Non-Covid Urgent Care	3. Elective Care	4. Public Health Burden of Pandemic Response	5. Staff and Carer Wellbeing	6. Innovation	7. Equity	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; covid survivorship)	(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 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 and established a new compact with them**	**#6 The positive innovations we made were retained, improved and generalised**	**#7 The new health and social care system that emerged was fundamentally more equitable and better at addressing inequalities**	**#8 The new system that emerged was higher quality, more productive and better governed**