East London Health & Care Partnership

North East London Integrated Care System

Recovery Plan Summary

27/05/2020

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Purpose

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The impact of Covid has tested the NHS to the limit; and we are still in an emergency situation. So we need to plan how we:

1. meet the existing challenge to provide Covid care
2. provide capacity and capability to manage future Covid or other pandemic peaks in a way that is more effective, less disruptive, safer for everyone and more efficient
3. continue to, and restart, safe delivery of non-Covid care, and clear the backlog of care.

This document has been compiled by working with partners. We are sharing it with the public and stakeholders to inform and engage all those who have a stake in ensuring the highest quality care for our local people.

Principles

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- The existing East London Healthcare Plans https://www.eastlondonhcp.nhs.uk/ourplans/ underpin our approach to recovery with strategic planning at the Integrated Care System (North East London) level and delivery through more local partnerships, boroughs and neighbourhoods.
- We should retain the best working practices from our experience of managing the Covid pandemic but we will test what we have put in place to ensure the changes meet the needs of the whole population, making adaptions where necessary.
- Staff are key to recovery and will be supported and fully engaged in defining and embedding new ways of working.
- Clinical leadership, supported by managers, is paramount. Decisions will be based on data and evidence. We will meet the requirements of the various clinical guides and NHS operating framework https://www.england.nhs.uk/coronavirus/
- Equalities will be woven through all aspects of the recovery & restoration programme.
- Health and social care will be given equal focus, and solutions will meet the needs of the population rather than institutions.
- Clear, two-way, diverse communications and engagement with local populations will shape and endorse changes.

12 Expectations

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NHSE/I have established 12 expectations from local health systems to meet the challenge of future healthcare needs. Many expectations focus on improvements local providers and commissioners of health have been trying to put in place for many years.

This plan sets out early thinking on how the north east London health system could meet the 12 expectations.

1. Build capacity

- ✓ A **permanent increase in critical care capacity** and surge capability, centred on tertiary sites
- ✓ **Minimise hospital stays** e.g. same-day emergency care; community-based rapid response
- ✓ Further **consolidation and strengthening of specialist services**

2. Prevent infection

- ✓ **Segregate the health and care system** between Covid and non-Covid; urgent and elective work especially by site
- ✓ **Virtual by default** unless good reasons not to be for e.g. primary care, outpatients, diagnostics, self-care
- ✓ **Single** 'talk before you walk' **points of access f**or all pathways
- ✓ New community-based approaches to managing **long term conditions (LTCs)**/shielded patients

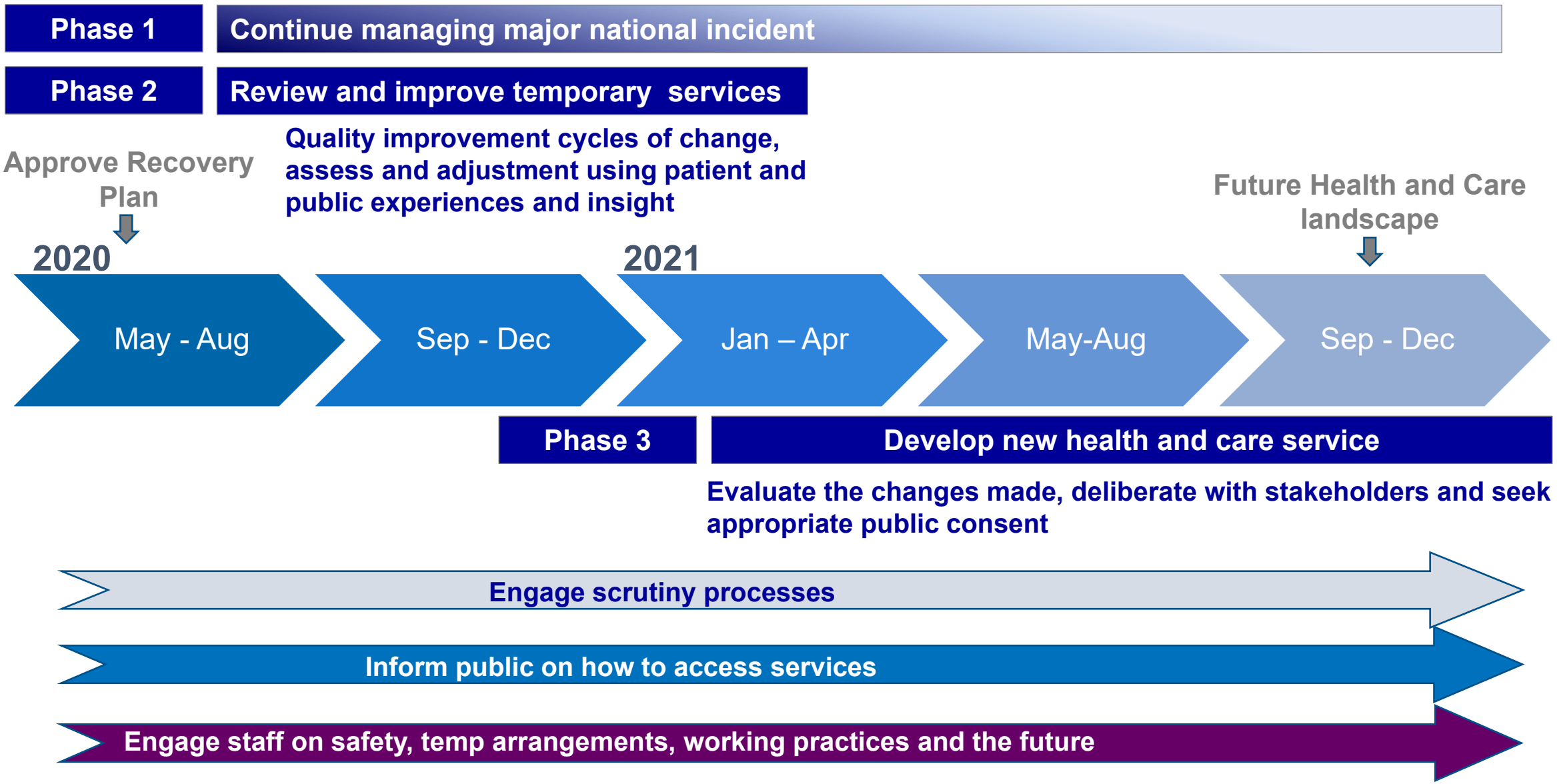
3. Develop a flexible workforce

- ✓ Consolidate **corporate services** and share **clinical support services**
- ✓ New integrated **workforce** and volunteer models and new incentives to deliver these new models of care
- ✓ Further **alignment and joining together of institutions** within the ICS

4. Put public and staff first

- ✓ Disproportionate **focus and resources for those with most unequal access** and outcomes
- ✓ A new approach to **consent** through systematic deliberative public engagement e.g. citizens juries

Indicative timeline



Summary plan (indicative dates)

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May to July 2020

1. We will engage with patients, public and stakeholders to gather evidence of the impact of recent and changes made to meet the challenges of the current emergency to ensure the changes deliver the intended benefits. We will seek to refine them to ensure the best outcomes for everyone.

June to Nov 2020

2. We will introduce new measures. This will enable us to resume planned care in the safest way possible, reduce the backlog of treatments, and be in the best position for any 2nd peak in Covid (or any other pandemic). In particular, t**he principles of infection prevention and control mean patients need to receive care in a fundamentally different way**. We will work with local people and partners to ensure the implications of these changes are carefully considered .

- **reduce urgent and emergency activity by at least 25%** to create capacity to manage planned care.
- **separate urgent and planned patients, Covid and non-Covid patients**. This can partly be achieved by redeveloping our estate, and partly by using new working practices such as virtual appointments, phone triaging etc.
- review and strengthen our actions to address **health inequalities** that are a) already in the system b) have become apparent in the way that Covid has affected parts of the population (for instance in mental health, children's services and care homes/domiciliary care, and c) may be caused by emergency measures
- build on the strengthened partnerships to promote and embed **integrated care** across all services, ensuring community settings are the default choice for service development. We will strengthen our partnerships with local authorities
- work with our **staff** to help them stay resilient and adapt to new ways of working using new technology

Continuous Engagement

Feb to Sept 2021

3. We will engage with patients, public and stakeholders to discuss their experience of services, the benefits and impacts of the changes; how we make the most effective use of the NHS estate and ensure equitable, high quality care for all.

Nov 2021

4. We will take decisions on the future of a new health and care system for London

1. Build capacity: what we have done

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✓ A permanent increase in critical care capacity and surge capability, centred on tertiary site

- Temporarily expanded our Intensive Care Unit (ICU) capacity; but this has drawn staff, space and equipment from elsewhere. Delivery has relied upon staff going above and beyond the normal call of duty.

✓ Minimise hospital stays e.g. same-day emergency care; community-based rapid response

- Strengthened our discharge teams to improve the speed of discharge; enhanced our Multi Disciplinary Team working
- Closer working with local authorities and targeted use of the Better Care Fund (BCF)
- Enhanced support to care homes
- Enhanced services for mental health patients and developed the crisis response via an all age 24/7 Crisis Line linked to 111 and the 24/7 Community Response Home Treatment service. This has been promoted via letters and texts directly to patients, via websites and through the voluntary sector response. 24/7 Crisis Hub established as alternative to A&E for mental heath assessments. Children and Adolescent Mental Health Service (CAMHS) 24/7 crisis response is via the CAMHS team 9am–9pm and 24/7 through other teams. Nursing teams are doing home visits to avoid mental health patients coming to a community clinic to collect drugs.

✓ Further consolidation and strengthening of specialist services

- Specialist care in NEL is already consolidated to a limited number of sites, and where there is multi-provider provision there is a programme of collaboration and alignment working towards operating as a single service across sites
- Single site services include cardiac surgery, complex cardiology (St Bartholomew's), bariatric surgery, (Homerton), Renal Transplant (RLH)
- Multi-provider services include vascular surgery and neurosurgery where there is extensive collaboration between BHRUT / Barts Health

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1. Build capacity: our plans for 2020/21

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✓ A permanent increase in critical care capacity and surge capability, centred on tertiary site

- Double the critical permanent critical care capacity from 183 beds to 366 beds. This will require a prolonged recruitment, development and retention programme. In the short term we need to ensure caring for Covid patients is shared by all those who have the skills
- Add surge capacity available within 48 hours to a total of 507 Intensive Treatment Unit (ITU) beds
- Consolidate additional critical care capacity at the larger sites to generate a more efficient workforce model and contain capital costs as well as making full use of the investment already made at the RLH

✓ Minimise hospital stays e.g. same-day emergency care; community-based rapid response

- Permanently strengthen our discharge teams and MDT working in the community as well as securing more community bed capacity and ensuring an improved model of support to care homes
- Pilot the “Think 111 First” proposals for the ‘talk before you walk’ access to urgent care pathways
- Introduce new tests for Covid so results can be known in 1 hour rather than a day; develop an improved offer for testing in care homes.

✓ Further consolidation and strengthening of specialist services

- For neurosurgery, neuro-oncological surgery is being consolidated to a single site at Queen’s Hospital, Romford
- In vascular surgery we are progressing the movement of complex aortic surgery to the Royal London Hospital
- Some specialist provision has a wider reach than NEL and plays a role in the delivery of specialist care for London. This includes cardiac services and Extra Corporeal Membrane Oxygenation (ECMO), and cancer services (St Bartholomew’s).
- Development of a business case to create a centre of mental health excellence at Homerton will create the capacity for the hospital to expand its theatre capabilities and specialists rotas.

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2. Prevent infection: what we have done

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✓ Segregate the health and care system between Covid and non-Covid; urgent and planned work

Consolidated and reconfigured some services and cancelled all but the most urgent planned, cancer and urgent care. We have increased our ability to treat mental health patients and people with learning disabilities in the community and increased crisis capacity.

✓ Virtual by default unless good reasons not to be e.g. for GP consultations or outpatient appointments

✓ New community-based approaches to managing long term conditions (LTCs) / shielded patients

Working with social care we have:

- rapidly deployed 'virtual by default'. For example, the number of virtual appointments in BHRUT has quadrupled. We also used telephones and video technology in primary care and the NEL 111 service particularly for at risk and shielded patients for triage and consultations; and introduced virtual routine care (e.g. in care homes)
- in mental health and learning disability services there has been a welfare check to prioritise those most at risk of admission; group and individual video call, phone and digital programmes; and text-based support and online counselling for children and young people (CYP). Moved to virtual Care, Education and Treatment Reviews for people with learning disabilities
- proactive identification of cohorts of vulnerable patients with LTCs at risk of exacerbation, with some improved use of telehealth
- enhanced use of Electronic Prescription Service and use of the NHS App for ordering repeat prescriptions
- developed separated places to treat Covid patients in each borough (hot hubs), with separate facilities in some GP practices; and home monitoring for symptomatic patients

✓ Single 'talk before you walk' points of access for all pathways

- 24/7 Covid telephone triage in primary care and out of hours urgent care.
- Enhanced sharing of systems and information to support direct NHS 111 bookings into practices (currently NHS 111 can book into 92% of GP practices).

2. Prevent infection: our plans for 2020/21

East London Health & Care Partnership

✓ Segregate the health and care system between Covid and non-Covid; urgent and planned work

- Separate hospitals, buildings or floors, staff and equipment (and separate critical care units) for planned and emergency patients
- Move the Urgent Care Centres and Urgent Treatment Centres at Queen's Hospital (QH), King George's Hospital (KGH), Whipps Cross (WXH), Newham (NUH) and Homerton (HUHFT) to be physically separate from Emergency Departments
- Review the small amount of consolidated children's care that has happened and develop an Elective Services Alliance including all NEL acute providers
  - Complex work will be consolidated at centres in St Bartholomew's Hospital (BH), RLH, QH sites and bariatrics at HUHFT
  - Centres for simple elective activity should be at KGH, NUH, WXH, HUH and other capacity at RLH and the independent sector
- Accelerate plans for a centre of mental health excellence for residents of City & Hackney and Tower Hamlets. Address the needs of Newham patients and in Barking, Havering and Redbridge (BHR) and Waltham Forest reconfigure and increase capacity at Goodmayes
- The presumption is that all maternity sites will treat patients irrespective of their Covid status and manage the risk accordingly.

✓ Virtual by default unless good reasons not to be

✓ New community-based approaches to managing long term conditions (LTCs)/shielded patients

- Continue existing changed services but partially revert to face to face consultations for some LTCs, especially for vulnerable groups (e.g. home visiting phlebotomy and anticoagulation services); restart face to face memory clinics; and enhance support for care homes, self-care support and home visiting
- Make online GP consultations available everywhere (97% of GP practices are live); launch a digital recovery platform for people with a serious mental illness; extend home monitoring and develop a London-wide patient facing app to deliver a wider range of LTC management to patients' homes
- Evaluate remote monitoring tools (such as wearable devices) and ensure patients are supported to access and use new technology
- Ensure all services can access the local shared care record and continue developing services for early LTC diagnosis/management
- Develop mental health bereavement support services.

✓ Single 'talk before you walk' points of access for all pathways

- Pilot 'talk before you walk' (including 'Think 111 First') access for e.g. cancer; trauma and orthopaedics; ophthalmology; urology; general surgery; Ear, Nose and Throat (ENT), and gynaecology); enhance sharing of systems and information, and social prescribing/volunteering services.

3. A flexible workforce: what we have done

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✓ Consolidate corporate services and share clinical support services

- A steering group has been established with membership from all five provider trusts and the CCG which aims to adopt an approach of full integrated collaboration to deliver better quality services and best value
- A significant amount of work has been carried out over the last year to explore the options around shared pathology. These plans are well advanced between Barts Health and the Homerton, and also take in Lewisham and Greenwich.

✓ New integrated workforce and volunteer models and new incentives to deliver these new models of care

- Established large scale agile and remote working which has resulted in skilling people up to work in different areas and specialties
- Established new and virtual multidisciplinary teams working across organisational boundaries, particularly to aid support of critical care and established a memorandum of understanding to enable swifter movement of staff to support mutual aid across organisations
- Shared and established consistent approaches to workforce issues such as staff testing and risk assessment.

✓ Further alignment and joining together of institutions within the Integrated Care System

- We have an established operating model that ensures alignment across our key organisations in north east London but with a key focus on delivery at a local system level: Waltham Forest, Tower Hamlets and Newham; Barking and Dagenham, Havering and Redbridge (BHR); and City and Hackney (C&H). We have had a provider alliance arrangement in place for some time across our acute care and mental health providers in north east London with leaders working closely together to resolve issues; and local borough arrangements coordinated in local systems
- These arrangements have been strengthened further during our Covid response, bringing together commissioners, clinicians, providers, local authorities, primary care and public health representatives to ensure resolution, escalation and system-wide planning across health and care.

3. A flexible workforce: our plans for 2020/21

East London Health & Care Partnership

✓ Consolidate corporate services and share clinical support services

- Explore potential for consolidation in: procurement; financial services; information management and technology; analytics and business intelligence; estates; and payroll. Procurement has been identified as an early exemplar and we have begun to develop a joint Personal Protective Equipment (PPE) hub for NEL. Barts Health has established some services within the group model that already provides some services to other NEL partners
- Building on the shared pathology work, this will be expanded in due course to explore options with the other partners
- Continue to explore opportunities of closer collaboration in e.g. diagnostic imaging, radiology and other clinical support services
- We expect an increased importance of community pharmacies in supporting services such as End of Life Care, and further expand electronic prescriptions and home deliveries for those most at risk and in isolation.

✓ New integrated workforce and volunteer models and new incentives to deliver these new models of care

- New and amended models of care/care pathways will need further development
- Investigate the impact of Covid-19 on BAME staff to inform how we ensure appropriate working environments and work patterns for vulnerable staff
- Build on recently developed skills and develop a pool of reservists through training, rotations, returners initiatives and to aid flexibility and responsiveness – explore potential for a bank, which could also address the challenges and costs of relying on agency staff
- Build on previous plans to consider talent management and leadership development
- Develop new workforce planning capability and workforce models, e.g. in critical care where the traditional models are no longer feasible.
- Consider the need for redeployment of displaced resources as a consequence of ‘virtual by default’ service consolidations
- Develop staff wellbeing services and additional mental health capacity and expertise to support the long term serious impacts on staff working through the Covid crisis and the continued pace of change required.

✓ Further alignment and joining together of institutions within the ICS

- We will continue to provide the overarching NEL system leadership and accountability for our plans; but gradually transition groups set up in the emergency back to being the Integrated Care Partnership Boards they were pre-Covid.

4. Putting the public and staff first: what we have done

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✓ Informing, engaging and involving patients, the public and our stakeholders

- We have a long tradition of public engagement and we have continued to work online with our partners and patient groups including running Patient and Public Involvement and Patient Engagement fora
- We have developed new newsletters and web pages to provide information and advice
- We held a virtual combined CCG governing body meeting to provide open scrutiny for the work of the Integrated Care System to what has been happening during lockdown, similarly the other statutory organisations are conducting board meetings virtually where possible
- The NEL clinical senate is being used to build clinical consensus on approach, and through an associated committee to check the ethics of our actions
- We have a system approach to communications and engagement, with a plan developed across partners to support our response to Covid.

✓ Reduce inequalities

- Our ethics committee has prioritised looking at the specific issues for our Black, Asian and Minority Ethnic (BAME) populations with recommendations for system action
- A health inequalities NEL-wide group involving all local authorities and key Trust and CCG public health leaders is looking to work with the voluntary and community sector to reduce inequalities for patients and staff
- Developed integrated neighbourhood and locality teams who convene multidisciplinary meetings with local authority experts in e.g. housing, debt advice and return to work programmes
- Established an Anchor-led programme of work to increase the social value of public sector resources in a given population. Local business procurement, local employment and local delivery are all part of this work. Additionally we are focused on social prescribing in every practice and we will be using social prescribing networks to help support patients who are digitally secluded
- Humanitarian aid responses co-ordinated through volunteer hubs led by local authority partners.

4. Putting the public and staff first: our plans for 2020/21

East London Health & Care Partnership

✓ Informing, engaging and involving patients, the public and our stakeholders

- Continue current engagement and develop new information to reflect the changes to services e.g. the new focus on virtual by default; and implement the NHS is open for business campaign to ensure that patients use the NHS when they need to
- Re-establish the system governance workstream to strengthen governance design, engagement, and patient and public participation in decision making
- Test the public's experience of using services differently during the pandemic through our/partner surveys/focus groups and with our online NEL citizens' panel. Hold sessions with our HealthWatch, patient representatives and new ICS Chair to discuss experiences, share plans and scope a programme of funded activity to test views and experience of patients
- Ensure there is sufficient debate and scrutiny of our plans for recovery and for the health and care system of the future
- Engage with scrutiny committees to discuss service changes made on safety grounds and discuss approach during recovery and beyond
- Ensure local people have a voice in any national or regional level engagement.
- Explore innovations in engagement and make better use of the mechanisms our partners use e.g. digital platforms and neighbourhood forums; whilst exploring the best ways to understand the views of all members of society (e.g. those who are digitally excluded or whose first language is not English).

✓ Reduce inequalities

- Weave the requirement to address inequalities and inequity into every aspect of our recovery plan and at all levels.
- We plan on using our Health and Wellbeing Boards to help lead and advise on addressing wider social determinants and use taxpayer funds wisely
- Use the NHS and local councils' anchor programmes (e.g. employment, apprenticeships and local purchasing power) to reduce deprivation and create and develop healthy and sustainable places and communities
- Ensure equalities impact assessments are undertaken; and assisted digital solutions are explored for the population that might be digitally excluded e.g. the use of local volunteers to offer safe alternatives to pathways where needed
- Understand the themes that helped/gave some resilience to Covid (e.g. financial security, secure housing, good social network, health conditions)
- Work with BAME communities and staff, where Covid appears to have had a disproportionate impact and review Covid effects on mental health; health promotion e.g. drugs, alcohol and tobacco; and on children and young people (food poverty, temporary housing, abuse and neglect).

Cross Cutting theme: Digital

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What we have done:

Our system *Digital Strategy* has enabled us to support the necessary changes in working practices during Covid including:

- The delivery of the Nightingale and all the digital tools needed to deliver patient care there - from test ordering to viewing shared care records
- The successful roll out of remote working tools to primary care such as over 1200 laptops and the scaling up of usage of video consultation tools (*GP practices across NEL are holding an average of 21 video consultations per week (range 0 to 112*))
- Linked up shared care records in London. This has seen the GP records and acute records as well as others being shared across most of London. We have also increased the scale of sharing with, for example, 111
- Developed dashboards which helped predict bed usage and support vulnerable patient searches. Shortly, 111 data will be live to enrich this data; and we established a capacity tracking tool to ensure warning signs were identified and actions taken
- Speedy roll out of digital solutions such as direct booking, online consultations and the Electronic Prescription Service (EPS).

What we want to maintain and plan to do:

In addition to the above, we are developing plans to further enhance performance in the following areas:

- Supporting increased improvement in the infrastructure at BHRUT
- Bringing care homes into the Digital First Accelerator project to improve digital services for patients, staff and visiting clinicians
- Speeding up the development and delivery of a patient facing app to enable patients to interact more directly with their records, their clinicians and their services
- Ensure that capacity trackers are used to inform our future actions and activity
- Look to appoint a system-wide Chief Information Office who will be part of the Integrated Care System executive team.

Key risks to delivery and our response

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1. These plans all require significant changes to the **workforce, the way we work and our ability to train and recruit people** to new roles. We also need to recognise that not everyone will want to change and many staff will have been affected by the emergency.
   - New ways of working, which will be paramount to delivering improvements, must consider the views of staff and endeavour to make their roles less burdensome, more productive and more fulfilling.

2. Some of these changes represent a **fundamental shift in the way many people will access health services**.
   - Current arrangements will remain in place whilst we engage with clinicians, staff and our diverse local population to further shape and define the new offer
   - We may need some support from NHSE/I on helping to manage some changes to services
   - The digital/virtual changes do not suit all service users and there are plans to return to face-to-face contact for example people with learning disabilities and autism as soon as is practical
   - Equality impact assessments will be required to ensure that no groups are disadvantaged by these changes and we reduce existing inequalities where possible. We will ensure that the full implications of these changes are assessed over time to make sure that the positive benefits are sustained, and any negative impacts are understood and mitigated against
   - The clinical complexity of patients is likely to increase and we must ensure our capacity reflects the impact of this on length of stay and the needs to rehabilitation in the community
   - The financial implications of these changes are significant, requiring capital investment and require resources to move around the system. We will develop a comprehensive financial plan and risk sharing approach to ensure that the resources are there to do the right things.

What next?

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Our NHS has stood firm in the face of incredible adversity. We recognise the amazing efforts of the many NHS, health and social care staff. The joint working between different health and social care organisations in this crisis has been inspirational. We need to build on these new and more positive partnerships and we owe it to our staff to build a stronger NHS in which a future pandemic does not require such sacrifices.

We need to meet the existing challenge to provide Covid care and reduce infections; provide more capacity; and restart, safe delivery of non-Covid care whilst still in an emergency.

- For many services we will be asking patients to continue using the new ways of virtually meeting with the NHS. It is safer, reducing the chance of patients contracting Covid-19 or other healthcare acquired infections (existing or future); more convenient for many patients; and it is more efficient, enabling us to spend our budget wisely.
- For services that need you to come into a hospital or NHS building we are following national advice and guidelines to minimise the risk of infection. Over the next few months we will be making every effort to segregate Covid and non-Covid patients, and planned and unplanned patients. This may mean that you are asked to attend a hospital that is not closest to you.
- Over the summer we will be engaging with patients, the public and key stakeholders to understand their experiences of new services and to ensure new measures we are taking are fit for purpose.
- Some of these changes are aligned with previously agreed plans. For instance, the health system has planned to separate some of our services for many years. Over the course of the next year we will be working with all those with an interest in developing a stronger NHS, particularly those who may be marginalised or who have particular needs, to work out how we can make this work for everyone. We will ensure we meet all the legislative engagement and consultation needs; and at the end of that time we will make decisions on a future NHS and care service that meets the needs of the whole population.

Glossary

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Word	Explanation
Anchor - led	Led by an organisation that, alongside its main function, can play a significant part in the local economy e.g. by buying locally.
Bariatric	Relating to obesity
Better Care Fund	A national fund created to support NHS/ local councils to together to integrate care
Cardiac / cardiology	Relating to the heart
Critical care / Intensive Care Unit (ICU) / Intensive Treatment Unit (ITU)	Specialised care of patients whose condition is life threatening
Diagnostic	Processes used to identify illnesses or the condition of a patient e.g. tests
Elective	Planned
Gynaecology	Study of women's and girls diseases, particularly reproduction
Integrated Care Partnership (ICP)	NHS organisations and local councils working collectively to improve the health of an area. In NEL there are three ICPs 1. Barking and Dagenham, Havering, and Redbridge 2. Tower Hamlets, Newham and Waltham Forest. 3. Hackney and City of London

Word	Explanation
Integrated Care System	NHS organisations and local councils that take a collective responsibility for the health of a region. NEL comprises the boroughs of Redbridge, Havering, Barking and Dagenham, Tower Hamlets, Newham, Waltham Forest, Hackney and the City of London
Neuro-oncology	Relating to cancers of the nervous system
Neurosurgery	Surgery on the nervous system
Nightingale	Temporary hospital built to care for Covid patients
Ophthalmology	Relating to eyes
Renal	Relating to kidneys
Social Prescribing	Health professionals referring patients to support in the community to improve their health and wellbeing
Surge capability	The ability to respond to sudden increases in demand
Tertiary	Relating to care that is specialised and only available at some hospitals
Urology	Relating to the urinary system
Vascular	Relating to vessels in the body