PLEASE NOTE – this document is a first draft and currently undergoing iteration and development with involvement of multiple partners

City and Hackney System Operational Command:

Phase Two Restoration and Recovery Plan

Draft submitted for HiH Scrutiny Commission (9th July 2020)

Produced by: City and Hackney System Operational Command

Background and context

- At the end of March 2020, System Operational Command arrangements were established in City and Hackney to provide a coordinated emergency planning and resilience response across the local health and care system during the pandemic
- During Phase One of the pandemic response, SOC co-ordinated operational leadership of the local system, ensuring successful joint working between GP practices, community health services, social care, mental health services, the voluntary sector, the local acute hospital, and links to wider public services. SOC was able to build on strong relationships and leadership structures which existed already through City and Hackney's integrated commissioning programme
- All transformation programmes and Workstream Programme Boards under City and Hackney's Integrated Commissioning Programme architecture were suspended, and the Integrated Commissioning Board moved to a short monthly update call
- During Phase One, System Operational Command was able to respond swiftly and effectively to the pandemic as CCG assurance and approval processes were streamlined and safely minimised. National changes, including the direction to suspend activity-based contract payments and implement block contracts supported this streamlined response
- As we move from the crisis footing of Phase One into a second 'restoration and recovery' phase, SOC's priorities will be to ensure that service delivery is fully restored in the context of the ongoing pandemic (addressing the 12 Expectations) but also to restart our existing programmes of transformation work and reshape our long term plan ambitions in a new context. In Phase Two SOC will move from managing delivery of a short-term Action Plan to a longer-term Integrated Delivery Plan
- SOC will need to continue to provide the swift and effective operational leadership of our pandemic response that it achieved during Phase One. It will also need to co-ordinate the delivery of our programmes of transformation work during a period of transition, as we implement the necessary changes to establish an Integrated Care Partnership within NEL ICS
- It will be for the statutorily accountable parts of our local system to decide upon the specific organisational, contractual and governance structures which will underpin the Integrated Care Partnership, drawing on wider changes at CCG and ICS level. SOC will be responsible for operationally delivering these changes as part of the Integrated Delivery Plan

An ongoing system commitment to reducing health inequalities

- The terrible toll exerted by the COVID-19 pandemic serves as another reminder of the deep social and economic inequalities which affect the health and wellbeing of our local populations
- The organisations that make up City and Hackney's local health and care system remain committed to a long term change programme which will move our focus from health and care service provision towards a better understanding of and response to the wider determinants of health; achieving more effective outcomes for local people and responding more holistically to the complexity of their needs, and to the specific needs of different local populations. Our vision of integrated care supports frontline staff to work with local people, harnessing their strengths and connecting them with resources to support their wellbeing; and advocating on behalf of our most complex and vulnerable service users
- This vision has run through our commitment to integrated commissioning, our Neighbourhoods programme, our local Long Term Plan response and through close partnership working between provider organisations. It will be at the heart of our Integrated Delivery Plan and will inform the restoration and recovery work of the SOC in Phase Two.

Our vision

Working together across City and Hackney to support people and their families to live the healthiest lives possible and receive the right care when they need it.

- **More support** for patients and their families to get healthy, stay well and be as independent as possible
- **Neighbourhoods** where people and communities are actively supported to help themselves and each other
- **Joined up support** that meets the physical, mental and other needs of patients and their families
- **High quality** GP practices, pharmacies and community services that offer patients more support closer to home
- **Thriving local hospitals** for patients when they need them

Our strategic objectives

We have developed five strategic objectives for the programme:

- **Deliver a shift in resource and focus on prevention** to improve the long term health and wellbeing of local people and address health inequalities
- De**liver proactive community based care** closer to home and outside of institutional settings where appropriate
- **Ensure we maintain financial balance as a system** and achieve our financial plans
- De**liver integrated care** which meets the physical, mental health and social needs of our diverse communities
- **Empower patients and residents**

The following partner organisations have been involved for some time in City and Hackney's existing integrated commissioning work:

- The London Borough of Hackney
- Corporation of the City of London
- City and Hackney NHS Clinical Commissioning Group
- East London NHS Foundation Trust
- City and Hackney GP Confederation
- Homerton University Hospital NHS Foundation Trust
- City and Hackney Local Pharmaceutical Committee
- Schools and Children's Centres
- Hackney Centre for the Voluntary Sector
- A range of local voluntary and community organisations
- Healthwatch City of London
- Healthwatch Hackney

SOC Phase Two Plan sections

City and Hackney SOC Phase 2 Plan sections	
OOH service recovery: Restoration, access & safety	This section of our plan sets out how we will ensure as a system that all Out of Hospital services: • Are fully restarted (where services have been reduced or paused as a result of the initial pandemic response) • Are compliant with Infection Prevention and Control guidance, inc. appropriate segregation and remote access • Have resilience plans in place to respond to surges in demand associated with a second peak • Have considered the equalities impact of service changes and taken steps to address these or escalate to SOC • Specific support to Shielded Patients, Care Homes, and packages of care for vulnerable people with LTCs
Restoration of elective work: Maintaining tight integration with the local system	• Linking our local support packages for long term conditions with changes in planned care • Ensuring that primary care and Neighbourhoods links and pathways with secondary care are maintained (ie. Advice and guidance, diagnostics, MDT involvement) • Ensuring effective local patient engagement, communications and co-design in relation to planned care restoration • Maintaining effective discharge pathways with changes to planned care
Updated transformation plans: Delivering our Long Term Plan and integrated care ambitions	• Integrated Delivery Plan for Phase 2 • Urgent care and rapid response – before hospital • Population Health Management and Intelligence • Clinical leadership – expanded role of Clinical Practitioner Forum • Inequalities Framework
Phase Two governance and support arrangements	• Revised SOC Term of Reference • Roadmap for creation of a local Integrated Care Partnership including SOC links to wider local system changes (establishment of a Neighbourhood Health and Care Partnership, establishment of single CCG) • Changes to our Strategic Enabler functions (Workforce, Digital and IT, Estates, Comms and Engagement, Community connection and VCS, Primary Care, and Population Health Intelligence • Revised system PMO arrangements

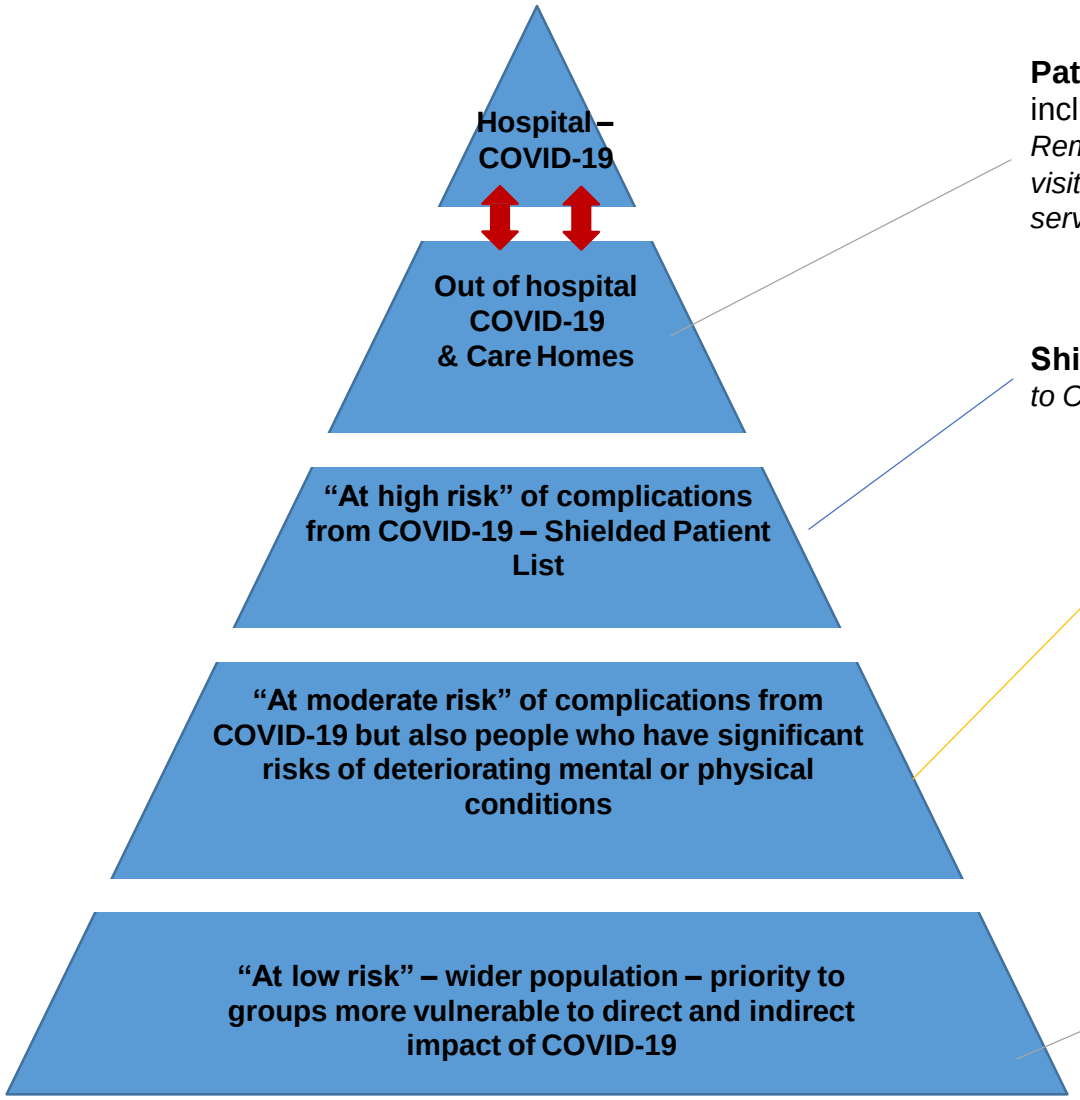
Out of hospital local service recovery:

Restoration, access and safety

SOC assurance on service safety, resilience and restoration

- During Phase Two SOC has a responsibility to ensure that local health and care services have resumed and are accessible and safe in the context of the pandemic response, and that service users are aware of changes to services, and that the equalities impact of changes have been considered and addressed
- Individual organisations remain statutorily and legally responsible for health and care services they provide, including CQC responsibilities. SOC does not intend to duplicate Board Assurance Frameworks and other accountability frameworks, but to co-ordinate a local system response
- During June 2020 SOC is requiring each organisation providing out of hospital health and care services to provide it with an assurance that all of their services:
    - Have plans in place during Phase Two to resume a **full service (**where services were reduced in scope or paused during the phase one crisis response)
    - Are **complying with infection prevention and control guidance in relation to service access and service segregation, as well as safeguarding guidance**, and have plans in place for delivering any remedial actions and deadlines for resolution
    - Have prepared **emergency resilience and surge plans in preparation for a second peak** of COVID-19 infections
    - Have effectively communicated service changes and engaged with **service users and communities** over service restoration work
- SOC acknowledges that the size of organisations and levels of risk involved in services will have an impact on their ability to respond. SOC will identify common themes where support and guidance may be needed, particularly for smaller grant-funded organisations
- In particular SOC will ask organisations to provide specific details about any problematic areas or risks in relation to these service restoration plans, and by mid-July SOC will develop a **Service Restoration Exception Plan**
- From mid-July a sub-group of SOC will ensure that all outstanding issues relating to IPC compliance, service access and restoration, the equalities impact of changes, and surge and resilience planning are escalated and resolved, and that all exceptions have been addressed

Our risk stratified response to COVID-19 in City and Hackney



Patients with COVID symptoms supported out of hospital including care homes –
Remote consultations, COVID treatment centre in primary care, visiting arrangements for a patient in their home, community services

Shielding Patient List ("At high risk") *–Defined according to Chief Medical Officer definitions (circa 1.28m nationally).*

Vulnerable cohort ("At moderate risk") - *Medically vulnerable based on eligibility for flu jab – (circa 19m nationally).*

There is a national definition for those at moderate risk (eligibility for flu jab). Locally we would also add those who are vulnerable for social reasons (e.g. homeless) or because of mental health (e.g. SMI)

3. Wider population ("At low risk") – Wider population impacted by the changes associated with COVID-19 e.g. economic impact

Restoration of elective work:

Maintaining tight integration with the local system

A NEL-wide approach to the restoration of acute elective work

Complex elective procedures

Complex elective procedures typically have more co-dependencies and require a more specialist workforce. Complex cases are higher risk and therefore require the strictest protocols for screening, testing and segregation. Therefore the first component of our model is the consolidation of complex elective care across a smaller number of sites. This will increase the resilience of the workforce for these services, and enable us to deliver these services in a COVID-protected space.

Complexity in elective care may refer to the nature of the surgery, the needs of the patient or both. There are patients who are complex and require additional support during their hospital stay.

Simple elective surgical procedures

'Simple' elective services are higher in volume and have greater throughput. In NEL there is a backlog of activity which needs to be worked through, due to the suppression of activity over the first COVID peak, against a backdrop of long waits in some services that must also be addressed.

The second component of the NEL-wide elective care model is the creation of high volume centres for the management of simple elective surgical procedures. This will enable us to make the most efficient use of our theatre space and workforce, as well as maintaining COVID protected space for elective care. To support the delivery of this, we are developing lead providers for our high volume specialties across NEL. Initial proposals for these lead providers have been developed, though they need further work before they can be formally agreed.

Outpatient services

The next component of the NEL model is the safe delivery of **outpatient services**. The COVID pandemic has expedited much transformation of outpatient services, including the expansion of virtual consultations, advice and guidance and community services. Retaining the progress made will be critical to our elective model going forward and we plan to move to virtual by default. Further work is required to assess how we should configure outpatient services across the sector while retaining equitable access.

Diagnostics

Finally, the delivery of diagnostics is a critical enabler for the model as outlined above and across NEL we have established a diagnostics and imaging hub with Barts Health as the lead provider to progress this work.

Local considerations in relation to the restoration of elective work

As part of the work under our Integrated Delivery Plan, in Phase Two we will work to ensure that:

- Our local proactive support packages to primary care for specific cohorts of patients with long term conditions (who are at greatest risk of exacerbation or deterioration) continue to link in with proposed changes in elective care delivery, including diagnostics, monitoring, outpatient activity and advice and guidance links to secondary care clinicians
- Effective MDT links with secondary care which have been established through the Neighbourhoods programme and PCN development are maintained during changes in elective pathways
- Our plans for communications and engagement will ensure that:
    - The successful Practitioner Forum which we established during Phase One is fully informed and engaged in changes to elective care
    - We effectively explain these changes to local people and service users and involve them in co-design and co-production of changes where possible
- The rapid discharge pathways we have developed in partnership with social care partners remain effective in the context of any changes to elective care pathways
- Our local system approaches to cancer screening, diagnosis and referrals are still effective
- We work as a local system to recast our operating plan in the light of changes in activity in the past few months to ensure that resources continue to be allocated most effectively

Based on analysis of local non-elective emergency admissions for high risk conditions in March and April compared to a baseline of previous years, data shows a concerning drop in activity which potentially suggests a 'storing up' of presentations of acute illness, which could lead to a peak of non-COVID-related emergency admissions in the coming months. Our plans to address this risk include:

- Working with partners to further analyse data to understand whether a reduction in emergency activity could be the result of more effective out-of-hospital interventions - and if so, building our learning from this
- Ensuring that further activity and capacity planning and analysis is done in the high-risk areas which gave greatest cause for concern: MI, ischaemic heart disease, cellulitis, sepsis, heart failure, COPD, asthma, diabetes and paediatric injuries

Updated transformation plans:

Delivering our Long Term Plan and integrated care ambitions through Neighbourhoods

Our Integrated Delivery Plan

Building on the success of our co-ordinated system leadership in phase one, we believe that a future system delivery plan is best organised around a single **thematic view** of groupings of **population health outcomes and improvement areas** rather than four or five plans reflecting the way that services are structurally organised

Our Integrated Delivery Plan is featured as a 'plan on a page' on the next slide, and SOC is currently going through a process to develop a full and detailed plan to use in co-ordinating our work during Phase Two.

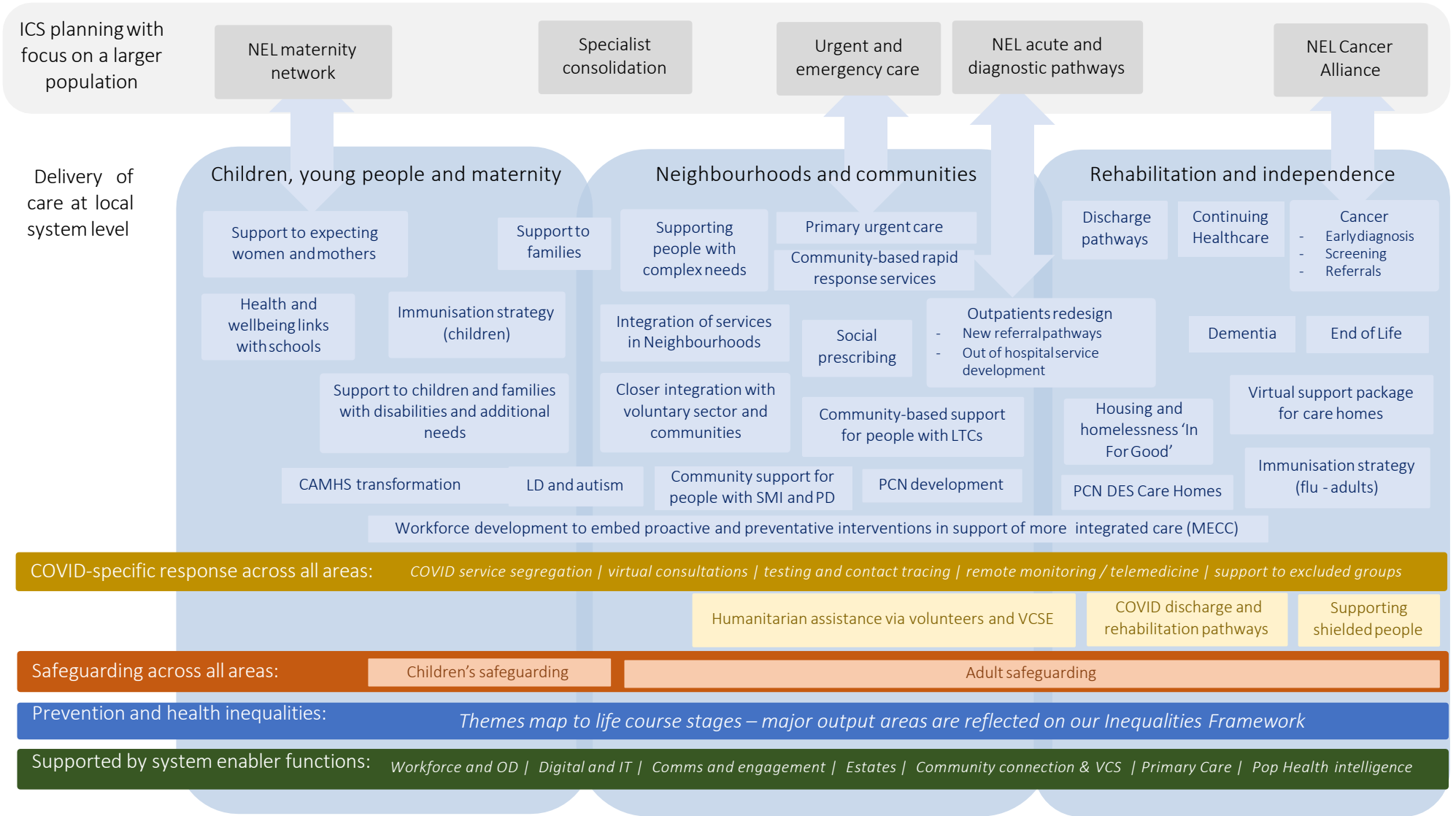
The functional areas we have grouped our planning actions around:

- Follow the aims of the Long Term Plan in wishing to avoid the influence of historic organisational and contractual structures, with greater priority placed on keeping people healthy and independent in **out of hospital** settings (at home or in the community)
- Loosely map to **life course stages**, in order to link with wider partnership work on reducing health inequalities
- Maintain our focus on **Neighbourhoods** as the building blocks of integrated community support
- Encourage a focus on **population health outcomes, prevention** and **wellness (**as opposed to illness) as supported by local residents through our Outcomes Framework

It is our aim during Phase Two to build a single delivery-focused view of our various transformation plans as a local system which encourages cross-cutting approaches and the greater collaboration necessary to deliver integrated care. This will include consideration of how best to utilise and develop existing integrated programme approaches.

Integrated delivery plan on a page – functional areas

This high-level plan details the major programmatic areas of integrated health and care provision which will be delivered by local mental health, primary care, social care, community health and voluntary sector organisations working in partnership in City and Hackney



A focus on neighbourhoods and communities

Our Neighbourhoods Programme continues to be at the heart of the way we are organising out-of-hospital services, managing our population health response and collaborating with Primary Care Networks and local public services. In Phase Two key actions and milestones are:

High-level actions in Phase Two	Milestones	Functions on the Integrated Delivery Plan this meets
Phase one: Establish adults MDTs across all Neighbourhoods to support people with complex needs and begin to capture learning	Now to end of July 2020 (this is to cover the period we've asked PCNs to chair / lead initially although the will have all launched by mid-end of June)	Supporting people with complex needs Integration of services in Neighbourhoods
Phase one: Establish children and families MDTs across all Neighbourhoods to support people with complex needs and begin to capture learning	Now to end of July 2020 (to be checked with Amy Wilkinson)	Support to families Supporting people with complex needs Integration of services in Neighbourhoods
Phase two: Embed adults and children and families MDTs in all including the provision of OD support for leadership and wider Neighbourhood team.	July 2020 to end of March 2021	Integration of services in Neighbourhoods
Develop and agree a sustainable model for all Neighbourhood MDTs. This includes MDT chairing, administration and a sustainable model for care coordination / navigation.	End of September 2020 (sustainable model commencing from 2021/22)	Support to families Supporting people with complex needs Integration of services in Neighbourhoods
Initial development of population health needs and inequalities (in light of COVID-19) and identification of priorities within Neighbourhoods	End of September 2020	Prevention and health inequalities (cross-cutting)

In Phase Three the following high-level actions will take place by March 2021:

- Evaluation approach established to capture the learning / impact of Neighbourhood Teams and MDTs
- Deliver service transformation to fully align services with Neighbourhoods in the following areas (for the adults MDT): Adult Community Nursing, Adult Community Therapies, Adult Social Care, Mental Health, Care coordination / Community Navigation and Voluntary Sector
- Develop and test models for Neighbourhood Partnerships including learning from other areas
- Further development and engagement of population health priorities within Neighbourhoods

What the Neighbourhood MDT looks like

What we are now working towards:

- Regular review of patients who are most vulnerable within a virtual Neighbourhood MDT
- A focus on supporting people with complex and acute needs and vulnerabilities
- A core group of professionals who are actively involved
- Resourced administration for Neighbourhood MDTs
- Effective routes of referral into virtual Neighbourhood MDTs initially from GP Practices but then from individual organisations
- Remote monitoring support to enable remote consultation wherever possible

Other supporting work in neighbourhoods and communities

Urgent care and rapid response before hospital

In Phase Two we will work with NEL partners to develop improved pathways from 111 to support reduction in ED attendances and agree specific pathways from 111 into primary care and into SDEC or hot clinics at the Homerton hospital site

Primary Care Networks development

PCNs are central to the clinical leadership and delivery of our vision for Neighbourhoods. In Phase Two we will:

- Work with PCNs to establish their role within the local system as providers and as system leaders
- Work with the GP Confederation to continue to support PCNs to develop their management infrastructure
- Continue to build capacity in Neighbourhoods teams so they can support PCNs to work with partners in taking a population health approach and provide multi-agency care

Community-based support for people with LTCs

In Phase One we developed local proactive support packages to primary care targeted to specific identified cohorts of patients with long term conditions (who have been identified as being at greatest risk of exacerbation or deterioration). In Phase Two this work will continue with further support for remote monitoring and telemedicine as well as self-care support and resources

Taking a population health approach

In Phase Two we plan to build on tools already provided by CEG and partners and request further support from NEL ICS colleagues with provision of more effective and proactive population health data tools to support targeted work at Neighbourhood and practice level

Supporting clinical leadership

In Phase Two we will expand upon and build the role of the Practitioner Forum which has been an effective virtual forum for clinical and practitioner leadership and engagement. We will adapt plans for embedding and supporting collaborative quality improvement projects led by clinical staff as part of our Neighbourhoods OD and PCN development work.

Closer integration with the voluntary sector and communities

In Phase Two we will confirm a local VCS Target Operating Model and establish the VCN strategic enabler by July 2020

Responding to mental health challenges in Phase Two

Mental health responses are embedded in our approaches across our Integrated Delivery Plan, reflecting our commitment to integrated care including consideration for wellbeing and recognising the impact of mental health on physical health. However, in Phases Two and Three we face a number of significant challenges, and our plan response is as follows:

High-level challenge	Plan response in next two weeks:	Plan response in next month:	Plan response by end of Phase Two:	Plan response in next six months:
Capacity to meet mental health demand HLP predict a 30% increase in mental health demand across London as a result of the pandemic. Services have reduced capacity due to high staff sickness and absence. LTP Mental Health investment is also largely on holding pending clarifications re. contracts and financial flows.	Mental health capacity and demand modelling completed highlighting key gaps	Develop costed plans to address gaps	Implement plans	Monitor implementation
Mental health inequalities Health inequalities for mental health service users have in many instances been exacerbated by the pandemic because of the effect of deprivation on the digital divide and access to the resources that maintain wellbeing, as well as the impact on cultural practices and communities.	Complete offer of SMART phones through personal health budgets	Agreed plans with providers for: i) Socially distanced IT hubs for patients who are not able to access digital services ii) plans for face to face contract prioritising patients who are either can not use or are not best served by digital services iii) clarifying BAME community group plans to support mental health within specific communities	Implement plans	Monitor implementation
Shielded and vulnerable patient psychological wellbeing Those on the shielded list and those part of vulnerable groups e.g. those with an LTC are likely to experience a higher level of mental health problems due to the the stress of an ongoing restricted lifestyle. People recovering from Covid may also be experiencing the effects of trauma.	Develop and send out psychological wellbeing pack for those on the shielded list with links to IAPT. Adapt the IAPT website to more clearly address Covid related needs.	Develop a stronger pathway between LTC patients and IAPT services	Monitor IAPT access and LTC access rate	Monitor IAPT access and LTC access rate
CAMHS return to schools The return to school presents an opportunity to resume the schools CAMHS Transformation Plans. This could however create a surge in demand. There are also risks attached to children who do not return.	Agree plans including how to reach children not returning	Implement plans including restoration of CAMHS transformation plans	Monitor implementation	
Return to BAU for suspended MH services *This will be covered under the first part of this plan, Out of Hospital Service Recovery, alongside all other health and care services*				

Addressing health inequalities in Phase Two

- The direct impacts of COVID-19 disease are disproportionately experienced by people from certain minority ethnic groups, older people, men, people with underlying health conditions, working in particular occupations and those living in socially deprived circumstances (untangling the contribution of these various overlapping risk factors is complex).
- The indirect impacts of lockdown and social distancing are also affecting some of the most vulnerable people and communities, including many of those described above as well as carers, certain faith communities, people with disabilities and those with no recourse to public funds.
- In Phase One SOC co-ordinated work to provide additional targeted support to vulnerable communities and groups such as the Charedi community and people in the community living with serious mental illness and personality disorder, working with community partner organisations. Our plans in Phase Two will build upon these targeted interventions and go further in tackling long-standing inequalities.

City and Hackney SOC Inequalities Framework	
Purpose:	• To ensure phase 2 planning retains an explicit focus on reducing health inequalities • To form the basis of a population health framework for City & Hackney
Principles:	• We will prioritise actions which target those who have been most detrimentally affected by COVID-19, and where we can make most impact as a partnership (taking a stratified approach) • No action will be taken as part of our phase 2 plans that further exacerbates pre-existing inequalities • Longer-term, we will continue to prioritise actions to reduce long-standing inequalities
Tools:	• Prioritisation matrix: a visual tool to highlight priority areas for action and help identify gaps/where plans not already in place • Decision-making tool - rapid EIA to guide decisions about phase 2 plans and make explicit our expectations about inequalities impacts • Equalities 'dashboard' - to monitor progress/impact of our actions

Phase Two governance:

Towards a local Integrated Care Partnership

Changes in governance during Phase Two

- We are moving from the reactive crisis footing of Phase One into the second phase of our response to COVID-19, and SOC is required to co-ordinate a 'new normal'; addressing both the new realities of service delivery under the pandemic (addressing the 12 Expectations) but also continuing to make the necessary changes to deliver our local long term plan response as an Integrated Care Partnership within NEL
- NEL ICS is maintaining level 4 incident command and control for phases one and two of the recovery plan, and during phase two other SOC groups within NEL are renaming themselves as Integrated Care Partnership Delivery Groups, in acknowledgement of this transitional phase for local systems. In Phase Three NEL will implement the ICS structures it will agree over the next 5-6 months.
- It will be for the statutorily accountable parts of our local system to decide upon the specific organisational, contractual and governance structures which will underpin the Integrated Care Partnership, and this will draw on wider changes at CCG and ICS level. SOC will be responsible for operationally delivering these changes as they are agreed, and they will form part of the Integrated Delivery Plan

This section of our plan sets out:

- Revised Terms of Reference for the SOC in Phase Two of recovery and restoration
- Changes to our Strategic Enabler functions (Workforce, Digital and IT, Estates, Comms and Engagement, Community connection and VCS, Primary Care, and Population Health Intelligence)
- Revised system PMO arrangements

Terms of Reference

Membership

Tracey Fletcher – Chair
Stephanie Coughlin (GP Clinical Lead)
Catherine Pelley (Nursing Lead)
Nina Griffith (Workstream Director)
Siobhan Harper (Workstream Director)
Amy Wilkinson (Workstream Director)
Jayne Taylor (Workstream Director)
Dan Burningham (Workstream Director)
Richard Bull (CCG Primary Care Director)
Simon Galczynski (Adult Social Care LB Hackney)
Chris Pelham (City of London)
Laura Sharpe (C&H GP Confederation)
Dean Henderson (C&H Borough Director, ELFT)
Sallie Rumbold (Community Health Services)
Mark Golledge (Neighbourhoods Lead)
Vanessa Morris (Voluntary & Community Sector)
Nic Ib (PMO)

Minimum meetings frequency

- Weekly on a Thursday
- Papers circulated afternoon before meeting

Meetings and administration

- Nominated admin support –*PMO team*
- Actions formally logged
- Decisions taken
- Notes, actions, decisions out to all members within one day

Purpose & Remit

In Phase Two of the COVID-19 response, the C&H SOC group will perform three main functions:

- Finalising and implementing the recovery plan for the City and Hackney local system, including recasting local transformation plans in the context of the 'new normal'
- Tracking activity and capacity locally to respond quickly to early signs of a second peak in COVID-19 infections and to initiate necessary resilience plans
- Co-ordinating our strategic programmes of delivery at system level during a transition period when governance and structures will adapt in preparation for establishing an Integrated Care Partnership in City and Hackney during Phase Three

At weekly meetings the group will review delivery progress against the SOC Integrated Delivery Plan and regular population health modelling reports.

The group will establish more effective and direct relationships with the local system strategic enabler functions so that their work more effectively supports delivery of the SOC Integrated Delivery Plan

The group will engage with NEL ICS workstreams as necessary and will escalate 'asks' to these in relation to local delivery work. The group will report in to the NEL ICS Recovery and Restoration Group as required, who will provide overall oversight for the ICS Recovery programme

In Phase Two the SOC will continue to provide a forum for leads to discuss challenges in development and/or implementation of plans and to seek support in resolving issues.

Activities OUT of scope

Non-Covid-19 related activities other than consideration of plans for phase three of the recovery and restoration plan.

Accountability and Authority

Accountable to NEL ICS Recovery and Restoration Group

Close liaison with Accountable Officers Group to ensure appropriate governance for significant decisions which impact on system partner organisations

Key interdependencies with other working groups and ICC activities

- City and Hackney C-19 Health Protection Board (formerly Pandemic Leadership Group)
- Local authority local resilience forums
- NEL ICS workstreams

Accountability and authority

City and Hackney Integrated Care Board

Acting as Local Outbreak Control Board providing public-facing oversight of local public health response

City and Hackney Accountable Officers Group

Providing a periodic opportunity to step back from the immediate focus of System Operational Command / ICS DG and reflecting strategically on the wider links to the local authorities and local partners

LB Hackney
Local Resilience Forum strategic co-ordination group

Gold: Tim Shields

City of London
Local Resilience Forum strategic co-ordination group

Gold: Peter Lisley

Escalation

City & Hackney System Operational Command (Integrated Care Partnership Delivery Group)

Chair: Tracey Fletcher (Homerton CEO)

Operational system management of the major re-organisation of provision within the local health and care system, in response to COVID-19

Escalation

Escalation

NEL ICS Recovery and Restoration Group
(formerly Strategic Operational Command)

Chair: Jane Milligan (AO)

NEL workstream groups:

- Acute care
- UEC
- Cancer
- Out of Hospital Care
- Public health
- Primary care
- Mental health
- Maternity

Enablers (Finance, Digital, Corporate Governance, Comms, Workforce, Estates)

C-19 Health Protection Board (formerly Pandemic Leadership Group)

Chair: Sandra Husbands (Dir Pub Health)

- Provide infection control expertise
- Lead development and delivery of Local Outbreak Plan (DPH)
- Link directly to regional PHE team and London Coronavirus Response Cell (LCRC)

SOC/ICP DG Leads

System Operational Command / ICP DG Leads are accountable for delivery of the Integrated Delivery Plan:

Stephanie Coughlin (GP Clinical Lead)
Catherine Pelley (Nursing Clinical Lead)
Nina Griffith (Workstream Director)
Siobhan Harper (Workstream Director)
Amy Wilkinson (Workstream Director)
Jayne Taylor (Workstream Director)
Dan Burningham (Workstream Director)
Richard Bull (CCG Primary Care Director)
Laura Sharpe (GP Confederation)
Simon Galczynski (Adult Social Care LBH)
Chris Pelham (City of London)
Dean Henderson (Borough Director, ELFT)
Sallie Rumbold (Community Health Services)
Mark Golledge (Neighbourhoods Programme Lead)
Vanessa Morris (Community and Voluntary Sector)

Support required from system enabler functions during Phase Two

- During Phase One of the COVID-19 response, we did not formalise links between existing system enabler functions and SOC, although several SROs of enablers are members of SOC
- These functions are essential to delivery of Phase Two recovery plans and it will now be appropriate to agree clearer lines of responsibility in relation to SOC in order to align the work of enablers more effectively with phase two operational delivery
- In June and July, SOC will work to more directly align the work of the enabler groups with integrated delivery plans and programmes of work, including establishing a population health intelligence enabler group.
- This work will go hand in hand with the development of the Integrated Delivery Plan

Workforce

- System workforce strategy & vision to support integrated care in Neighbourhoods
- Workforce planning
- Education & Training
- System Organisation Development support & cultural change
- Nursing/midwifery/AHP leadership and engagement
- Psychological impact of the pandemic on staff

EXISTING

Digital and IT

- Single view of a person's health and care record
- Coordinated care and care planning
- Information and control for patient/empowerment
- Supporting a co-ordinated local approach to virtual consultations and telemedicine

EXISTING

Estates

- Local system estates strategy & planning
- Capital & investment strategy
- Estates delivery
- Primary care provision
- Commercial developments
- Corporate governance: estates and facilities

EXISTING

Comms and engagement

- Overarching system-wide communications & engagement
- Intelligence on community and service user responses to pandemic
- System support for co-design and co-production
- Support for legal consultation duties in response to service changes

EXISTING

Community connection and VCS

- Local system co-ordination of work involving links with community organisations and the voluntary sector
- System co-ordination of community navigation and connection roles and functions

EXISTING

Primary care

- Responsible for ensuring that population-level enhanced services contracts support admissions avoidance, LTP ambitions and integrated of services through PCNs in Neighbourhoods
- Required as part of delegated primary care commissioning governance

EXISTING

Population health intelligence

- Responsible for modelling local COVID-19 response and co-ordinating local early warning triggers for second peak response
- Population health – data sets and support for anticipatory care and other data-informed new service models

NEW

Revised PMO arrangements during Phase Two

- In support of establishing our Integrated Delivery Plan, during June and July, SOC Leads will arrange for PMO and programme leads from major transformation programmes to co-ordinate with each other and review opportunities to streamline and simplify programme support and reporting arrangements. This will also be informed by plans for development of a local Integrated Partnership Board.

Appendix

Reminder of the 8 tests and 12 expectations

SOC Phase Two: Reminder of 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. 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 pandemic needs	**#2 We did everything we could to minimise and morbidity causes**	**#3 We returned to the right level of access elective cases clinical need**	**#4 We put in place an effective other effects on the pandemic**	**#5 We helped our people to recover from pandemic and new compact with them**	**#6 The positive innovations we made during were retained, generalised**	**#7 The new health and social care system that fundamentally addressing inequalities**	**#8 The new health and social care system that materially higher productive and better governed**

SOC Phase Two: Reminder of 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