London Clinical Senate

London Clinical Senate Forum

17th May 2018
9.15 – 13.00

Building System Leadership for Integrated Care

London Clinical Senate

Welcome and introduction

Dr Vin Diwakar
Medical Director, NHS England London Region
Clinical Senate Forum Co-Chair

London Clinical Senate

Aims of today

- Create a shared understanding of what the change from organisational leadership to integrated system leadership, including the responsibility for population health, will mean in practice and the competencies it requires.

- Identify the both the enablers and barriers to developing system leadership skills at different levels and across teams.

- Agree the steps required to support leadership development and facilitate the delivery of integrated care systems that will benefits patients, carers and our fellow Londoners

London Clinical Senate

How is system leadership developing in Integrated Care Systems?

Chris Ham
Chief Executive, The King's Fund

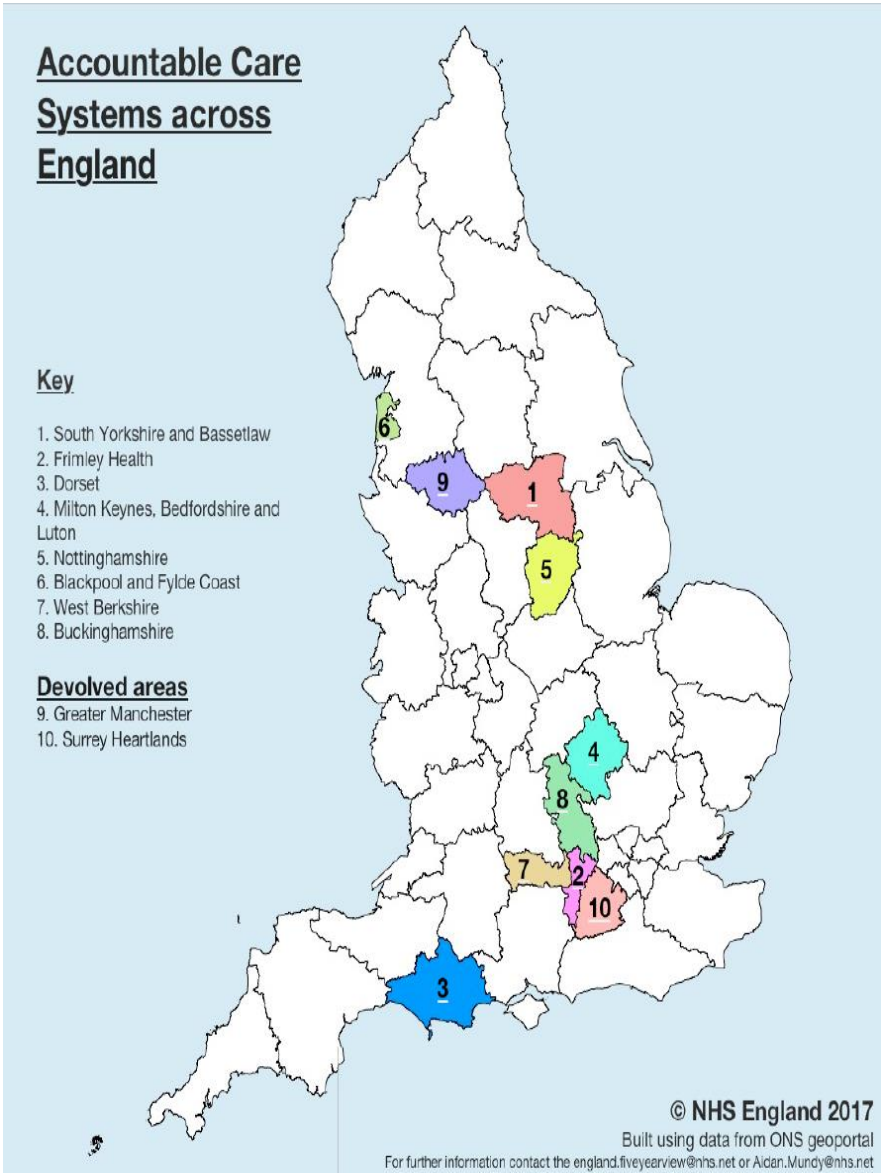
How is system leadership developing in integrated care systems

Chris Ham
Chief Executive
The King's Fund

17 May 2018

The King's Fund

Accountable care areas in England

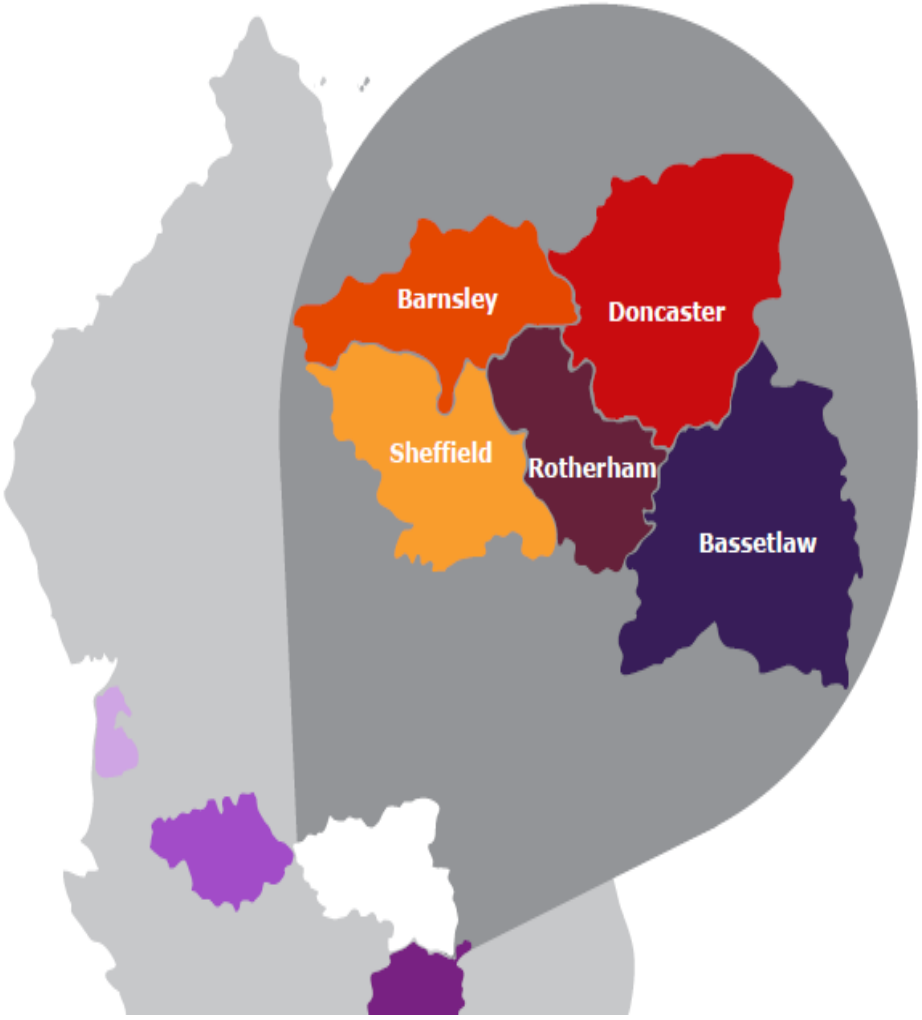


Integrated care systems (ICSs) have evolved from Sustainability and Transformation Partnerships (STPs) and take the lead in planning and commissioning care for their populations and providing system leadership.

They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area.

Integrated care partnerships (ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

South Yorkshire ICS



Challenges

- The statutory framework does not make this work easy
- Much hinges on relationships and trust
- Regulators are often slow to align behind ICSs
- Key leaders face competing demands
- LAs are key partners in some areas but not in all
- JR challenges have raised concerns about privatisation
- ICSs must begin delivering to reassure sceptics

Some personal reflections

ICSs have the potential to be a real game changer, but are at different stages of maturity

The language of accountable care and the lack of a publicly facing narrative have not helped

Much more attention needs to be paid to clinical engagement and community engagement

Organisational realignment without service improvements will not deliver the Forward View

International experience shows importance of clinical leadership and clinical integration

The King's Fund

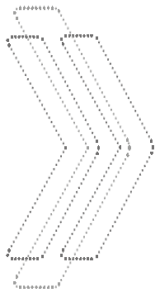
Ideas that change health care

Intentional whole health system redesign

Southcentral Foundation's 'Nuka' system of care

Author

Ben Collins



November 2015

The King's Fund

Ideas that change health care

Authors

Nicholas Timmins
Chris Ham

The quest for integrated health and social care

A case study in Canterbury, New Zealand

The King's Fund

Ideas that change health care

Developing accountable care systems

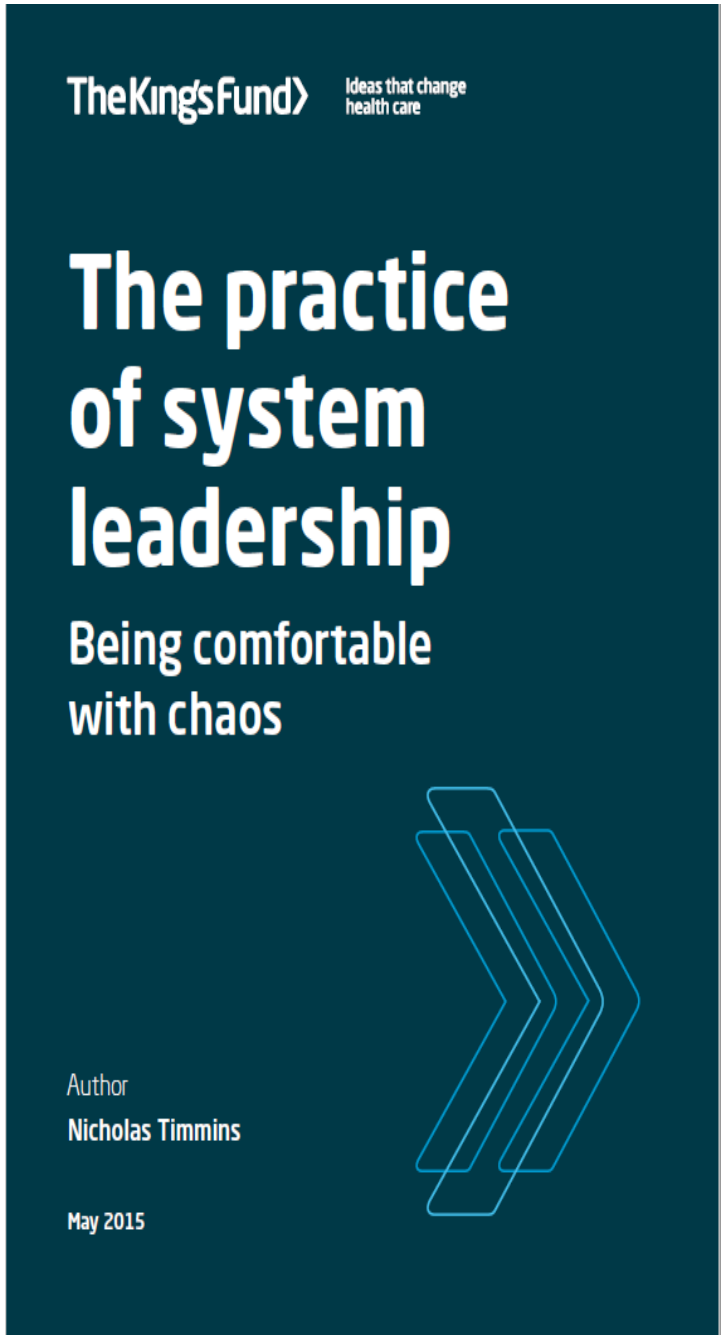
Lessons from Canterbury, New Zealand

Anna Charles

August 2017

How can system leadership be developed?

- A shared purpose and vision for the population you are serving
- Frequent personal contact to build understanding and trust
- Acommitment to working together for the long term
- An ability to surface and resolve conflicts, not letting them fester
- An ability to behave altruistically towards partners



Reflections

Much of this is ‘work in progress’ and ideas are still developing

ICPs and ICSs won’t work if relationships between providers in the partnership and between providers and commissioners are not well developed

Progress is often based on leaders who’ve worked together over time and a deep commitment to collaboration and the population served

Integrated care arrangements have to be ‘made in’ each place taking account of local relationships and histories

The relational challenges need as much attention if not more than the technical challenges

Progress occurs at the speed of trust

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The South East London Integrated Care Systems

Julie Lowe
Programme Director, South East London STP

Our Healthier South East London
Sustainability and Transformation Partnership

NHS

The South East London System of Systems

Or.. How do you lead when you no one's in charge?

Julie Lowe

Programme Director/ Chief Operating Officer

May 2018

Our Healthier South East London
Sustainability and Transformation Plan

NHS

A Plan, a Programme, a Partnership?

SECRET TORY PLOT?

Sticky Toffee Pudding?

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

What is an STP?

1. A planning footprint to address the three gaps identified in the 5YFV
   - The health gap
   - The care and quality gap
   - The financial gap

2. An STP …….
   - Has no statutory or legal basis, just the NHS working together in SEL with its partners and stakeholders
   - Started with a plan and evolved into a partnership
   - Is increasingly seen as co-ordinating body, *aligned with regulators*

3. It isn't a blueprint. It's a number of large and complex workstreams, some are better developed than others.

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Sustainability and Transformation Partnership

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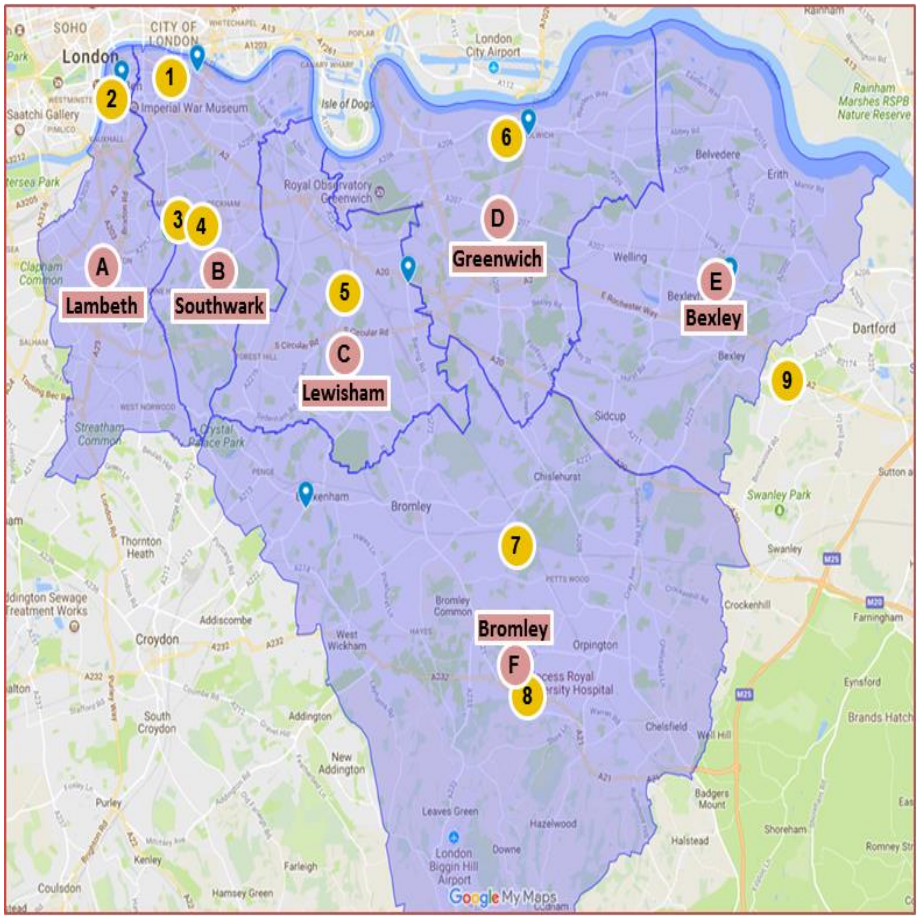

	4 SLaM	7 Oxleas	1 2 GSTT	3 8 Kings	5 6 LGT	9 DGT
A Lambeth CCG and LA	●	-	● ●	●	-	-
B Southwark CCG and LA	●	-	● ●	●	-	-
C Lewisham CCG and LA	●	-	-	-	● ●	-
D Greenwich CCG and LA	-	● ●	-	-	●	-
E Bexley CCG and LA	-	● ● ●	-	-		●
F Bromley CCG and LA	-	●	-	●	-	-

GSTT is a provider of acute services, and the main community provider, in Lambeth and Southwark

King's provides acute services across three boroughs (Lambeth, Southwark and Bromley)

LGT delivers acute services across Lewisham, Greenwich and Bexley, and community services in Lewisham

DGT sits outside the STP, but delivers a significant amount of work for Bexley

Oxleas delivers MH, community and social care in Bexley, MH and community services in Greenwich, and MH only in Bromley

Key

1 Guy's 2 St Thomas' 3 King's College Hosp. 4 South London and Maudsley 5 University Hosp. Lewisham

6 Queen Elizabeth Hosp. 7 Oxleas 8 Princess Royal University Hosp. 9 Darent Valley Hosp.

Key

● Acute ● Community ● Mental Health ● Social

This table shows the main boroughs for providers. Note: It is not exhaustive and excludes specialist acute and mental health, which is often provided across and beyond the STP

Our Healthier South East London
Improving health and care together

If we don't succeed, we will have to have to build the equivalent of another hospital in south east London to cope with the increase in activity.

NHS

SEL STP Plan on a Page

Our challenges

- **Demand for health and care services is increasing.**
- **There is unacceptable variation in care, quality and outcomes across SEL.**
- **Our system is fragmented resulting in duplication and confusion.**
- **The cost of delivering health and care services is increasing.**

Our five priorities and areas of focus

1 Developing consistent and high quality community based care (CBC), primary care development and prevention

- Promoting self-care and prevention
- Improved access and co-ordination of care
- Sustainable primary care
- Co-operative structures across parts of the system
- Financial investment by the system
- Contracting and whole population budgets

2 Improve quality and reducing variation across both physical and mental health

- Integration of mental health
- Reduce pressure on and simplify A&E
- Implementation of standards, policies and guidelines
- Collaborate to improve quality and efficiency through consolidation (e.g. Elective Orthopaedics)
- Standardise care across pathways

3 Reducing cost through provider collaboration

- Standardise and consolidate non-clinical support services
- Optimise workforce
- Capitalise on collective buying power
- Consolidate clinical support services
- Capitalise on collective estate

4 Developing sustainable specialised services

- Joint commissioning and delivery models
- Strategic plan for South London
- London Specialised Commissioning Planning Board
- Managing demand across boundaries
- Mental health collaboration

5 Changing how we work together to deliver the transformation required

- Effective joint governance able to address difficult issues
- Incorporation of whole commissioning spend including specialist
- Sustainable workforce strategy
- Collective estates strategy and management
- New models of collaboration and delivery

The impact of our plans

- Reduction in A&E attends and non-elective admissions
- Reduced length of stay
- Reduced re-admissions
- Early identification and intervention
- Delivery of care in alternative settings

(Net savings c.£119m)

Cross-organisation productivity savings from joint working, consolidation and improved efficiency.

(Net saving c. £232m)

- Increased collaboration
- Reduced duplication
- Management of flow

(Need to address £190m)

- Aligned decision-making resulting in faster implementation
- Increased transparency and accountability

A partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, with NHS England

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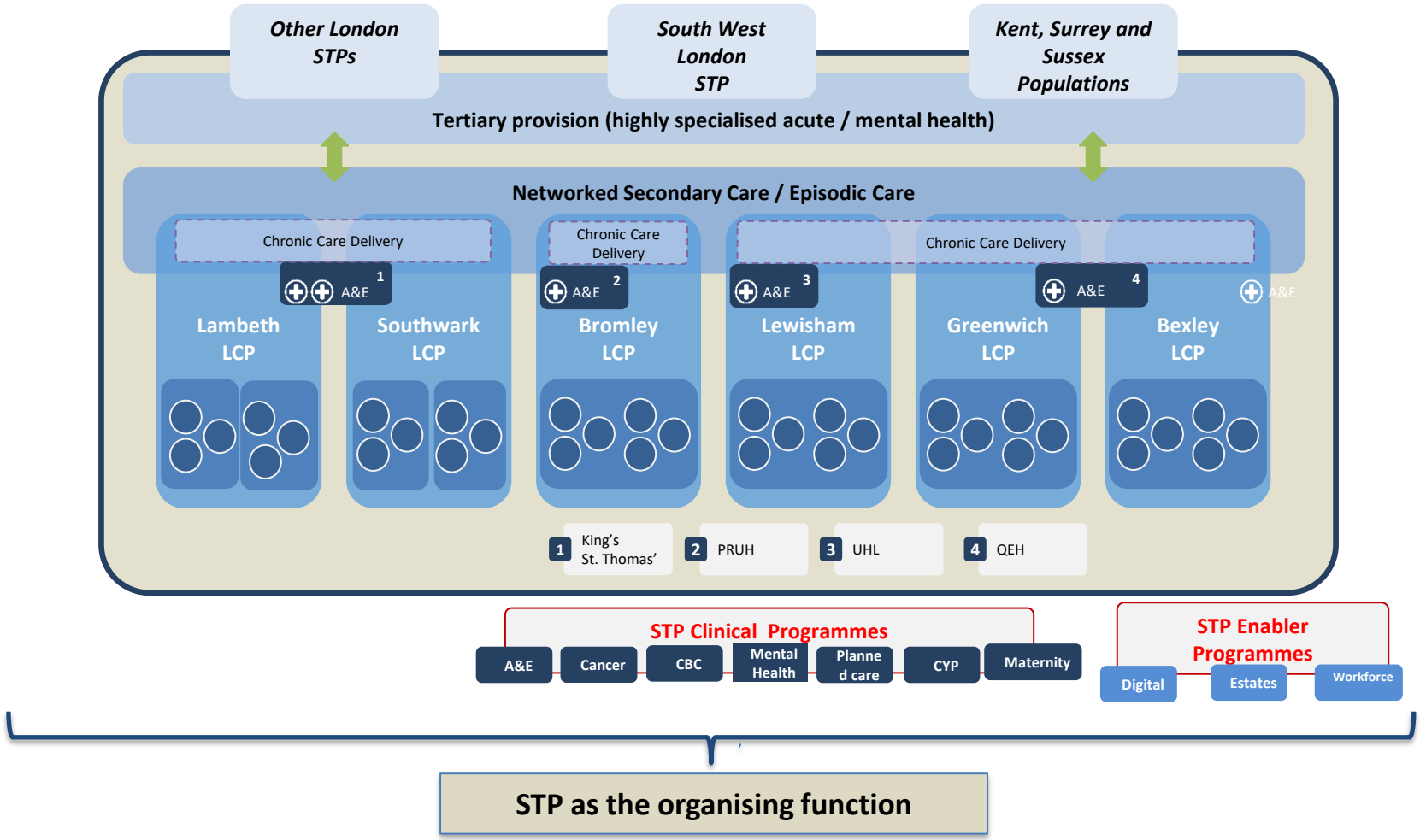
Sustainability and Transformation Partnership

NHS

What might integrated care look like?



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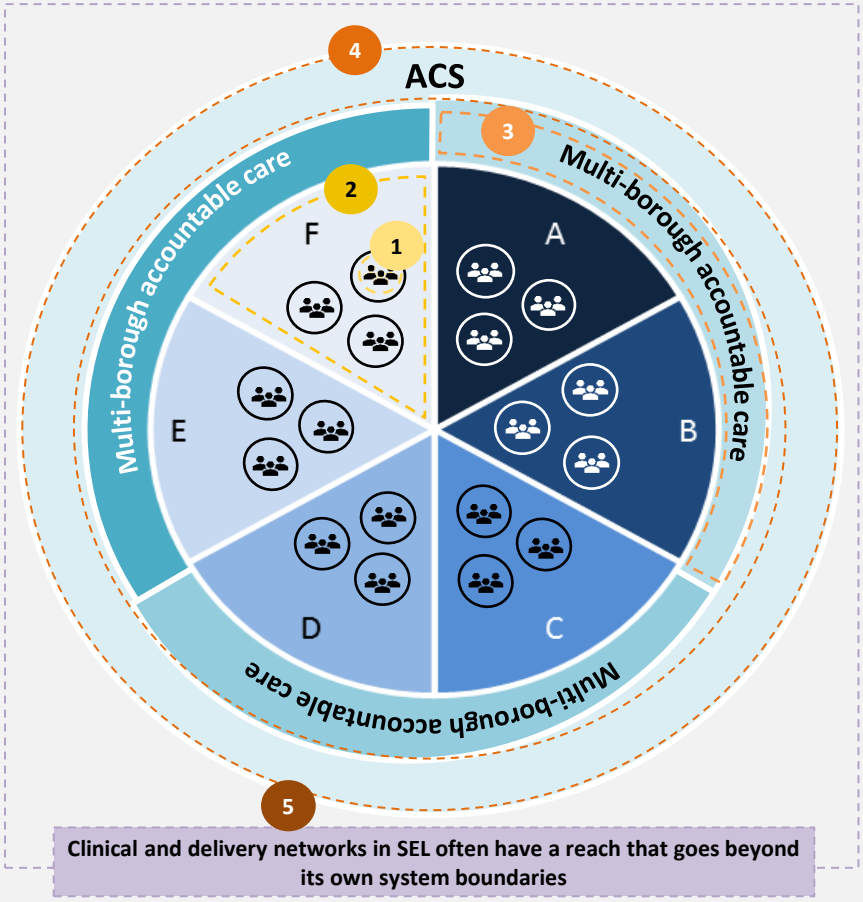
NHS



1 **Local Care Networks**
Services may be operationalised at an LCN level to focus on the specific needs of neighbourhood populations, building around GPs at scale

2 **Local Care Partnerships**
Borough-level systems will be accountable for the health of their population, with services delivered through local models

3 **Cross-Borough Partnerships**
Some health and care services are likely to benefit from delivery across multiple boroughs, where there are benefits of scale

4 **Integrated Care System**
Some services may be best delivered at the scale of SEL . The STP may also have other functional roles

5 **Beyond SEL**
Some services may be best delivered at a greater scale than the SEL STP

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Orthopaedic clinical network

- **In progress…**

- Focus is sustainable elective orthopaedics for SE London
- Detailed pathway mapping and comparison to ‘best practice’ initially for high volume inpatient procedures (hips and knees)
- Review of Getting It Right First Time (GIRFT) data and Right Care data for local CCGs and hospital sites
- Review of all activity across sites including day case activity and semi- elective work
- Links to trauma network

- **Next…**

- Agreeing common metrics across sites (outcomes, experience, efficiency)

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A system-wide perspective for cancer

Professor Geoff Bellingan
Medical Director, Surgery and Cancer Clinical Board,
University College London Hospitals NHS Foundation Trust

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Q&A followed by table discussion and feedback

To discuss on your tables (and record key points to feedback)

Reflecting on the presentations you have just heard about building system leadership for integrated care:

- What is different in behaviours required?
- What would good look like?
- What are the barriers and enablers?
- What support would assist?

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HIV services in London and Integrated Care Systems

Professor Jane Anderson
Homerton University Hospital NHS Foundation Trust

Dr David Asboe
Clinical Director for HIV Medicine and Sexual Health,
Chelsea and Westminster Hospital NHS Foundation Trust

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Integrated Care in Barking and Dagenham, Havering and Redbridge

Dr Jagan John
Chair, Barking and Dagenham Clinical Commissioning Group

BHR Integrated Care Partnership
Better care, better lives, together

Integrated Care System Development

Dr Jagan John

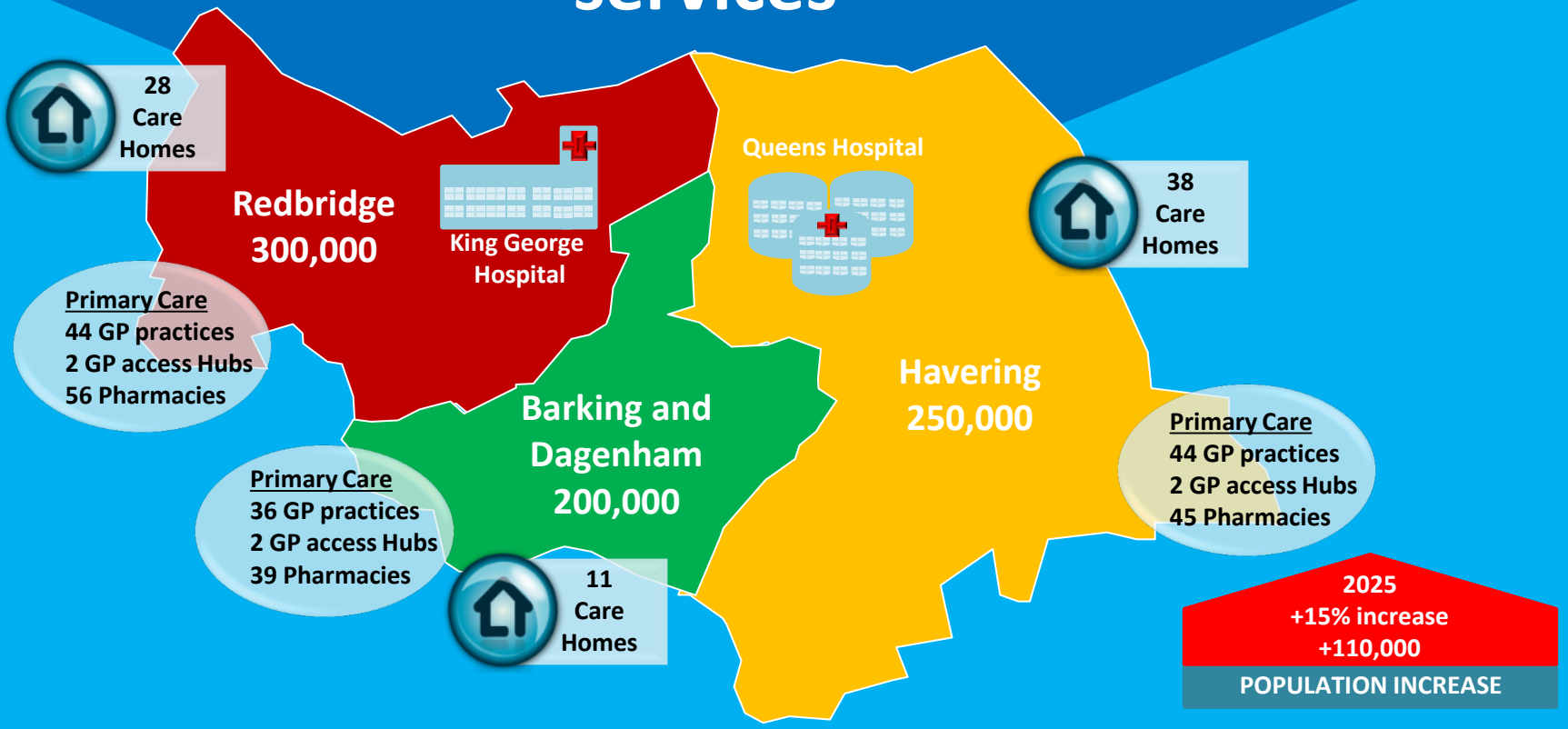
GP and Chair of Barking and Dagenham Clinical Commissioning Group
Proactive Care Clinical Lead (HLP)

17 May 2018





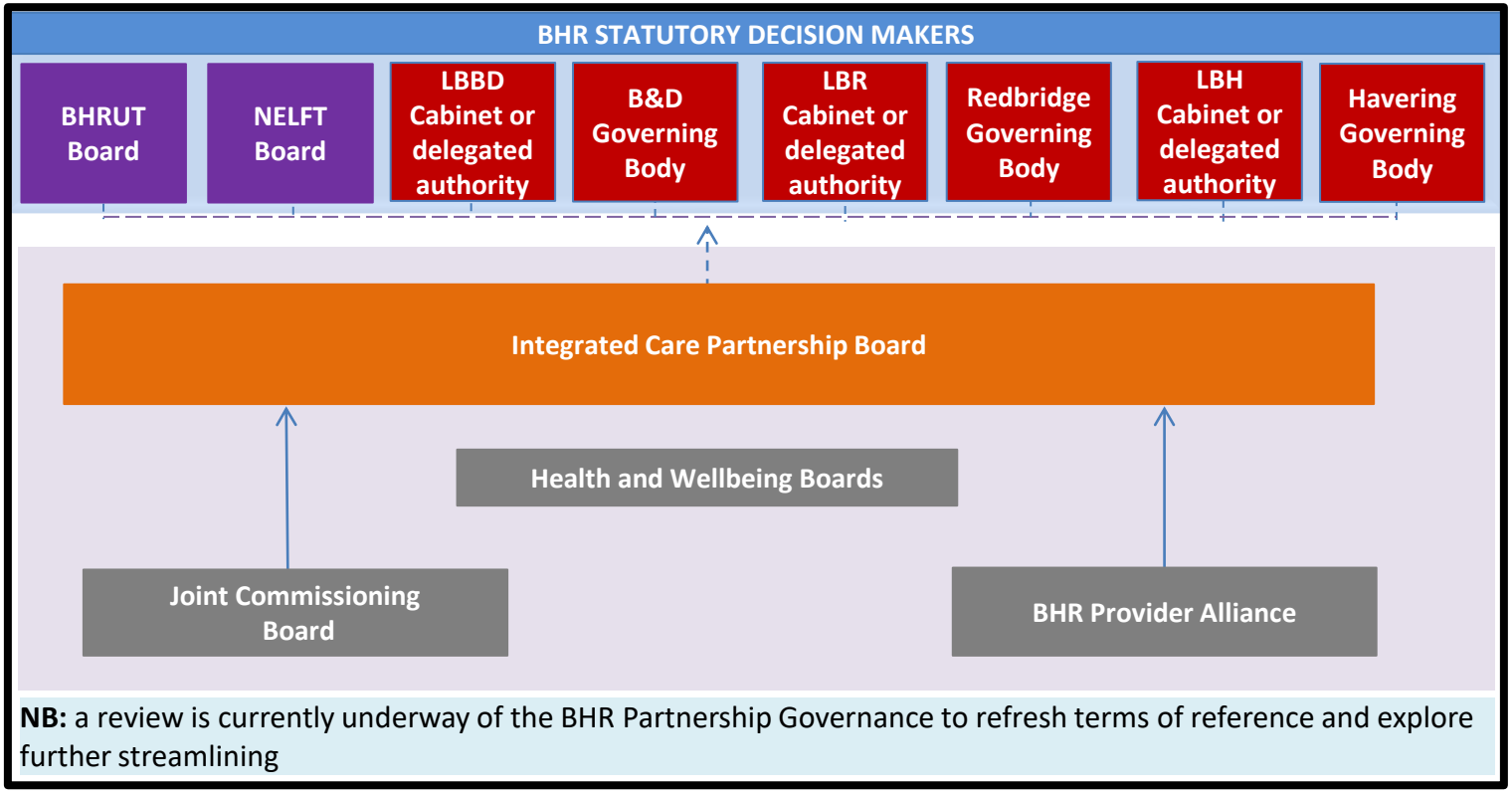

To accelerate improved health and wellbeing outcomes for the people of Barking & Dagenham, Havering and Redbridge and deliver sustainable provision of high quality health and wellbeing services



Barking and Dagenham, Havering and Redbridge Integrated Care Partnership statement of purpose

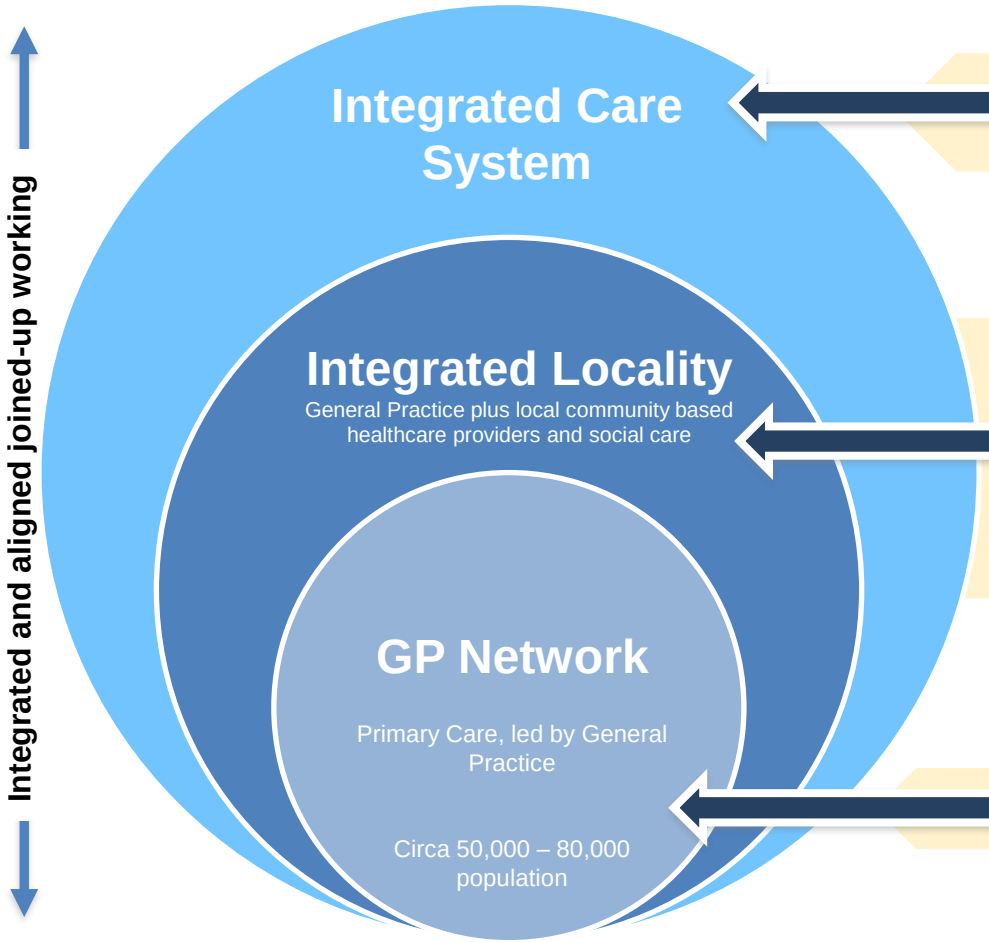
System working; our governance model

Health and care partners in BHR started formal partnership work from December 2011, which has evolved into the **Integrated Care Partnership Board** (ICPB)



The BHR Integrated Care Partnership Governance structure enables coordinated partnership working at a system level to allow the commissioning and delivery of services in additional to plans at individual borough level.

System working; our delivery model



Integrated Care System partnership working at a BHR level including the Community and Voluntary sector

Integrated locality extends the GP network to include all community providers to work collaboratively. A BHR team is developing a proposal through the UCLP/Dartmouth programme to test the benefits of place based, integrated care around Frailty

GP Network is the model for primary care at scale

The GP Network model is at the core of both the development of General Practice in its own right, and as the foundation of place-based, integrated care.

Benefits of partnership working

- **Partnership discussion** enables a whole system, **joined up approach** including joint monitoring of system performance and unblocking of issues in partnership

- Ability to **engage local people, staff and key stakeholders on a wider scale,** for example, we engaged with over 8,000 local people, health and care staff and the Community and Voluntary sector at a BHR level as part of the development of our Strategic Outline Case into the potential benefits of more Integrated Care in BHR. We have also established Care City to **test and embed innovation and new technology**

- Development of a **shared vision** from working together as a system on the BHR Integrated Care Case for Change (August 2012), and development of the BHR ACO Strategic Outline Case which set out our key health and care challenges at a BHR system level, and explored the benefits of accountable care for BHR. From this we have developed a clear vision around a more integrated, seamless commissioning and delivery of services across our three boroughs

- This vision has ensured that despite our work at a system level, we haven't lost site of the need to **develop a localised, population/need based approach** to the delivery of services

- Discussion and progress around the **Better Care Fund**

- Ability to **enable resources to be pooled at a BHR system level** to enhance services and avoid duplication, for example through the Joint Assessment and Discharge team and identification of gaps

- Strategic thinking and oversight at this level, informed by the operational information that is reported from key work streams, makes it easier to **remove barriers** across services and teams that prevent the delivery of seamless, joined up care

What have we achieved together so far?

Partnership work at a system level can take years to develop, and results are not always immediate.

The partnership work in BHR has already delivered some fantastic new services and improvements for local people however, particularly around the development of more cohesive out of hospital services including:

- **Better use of our resources around our Community services** including the establishment of wrap around, rapid response type services including our Community Treatment Team and Intensive Rehabilitation Service, significantly increasing community capacity
- Development of the **Significant 7 programme**; an award winning programme of training for Carers
- Establishment of our **Joint Assessment and Discharge Team**, streamlining discharge resources and processes
- Establishment of our **partnership governance structure**
- **Strong collaborative working** as three Clinical Commissioning Groups and commissioners
- **Testing of new, innovative models of care** including Health 1000 and

  Looking at support for care homes collaboratively
- **Establishment of Primary Care at scale** including GP Networks and

  GP Federations and key enablers such as IT to support this
- ICPB partners are in **discussion to apply the principles of integrated Place/population-based care in principle** e.g. around diabetes

Constraints

THE CURRENT FINANCIAL CLIMATE

COMMUNICATION

REGULATION

RELATIONSHIPS

SPECIAL MEASURES

TIME

TECHNOLOGY THAT SUPPORTS INTEGRATION

Trying to work differently within a STATUTORY FRAMEWORK that hasn't changed

Key points of learning

TIME and PACE

We have been on our partnership journey since 2011. Do not expect change to happen quickly

TRANSPARENCY

Partnership relationships thrive when there is openness and transparency so you must create a space for partners to be open with each other. We started by sharing our financial positions and mapping the gap at a system level, across health and social care

DEDICATED RESOURCE on top of business as usual

As a partnership we have been successful at dedicating key members of staff to contribute to joint initiatives across the system to drive transformation; for example, the changes around Intermediate Care, establishment of the Joint Assessment and Discharge Team, and the current UCLP/Dartmouth team working to develop a place based care proposal around frailty

RESOURCE to support engagement

In 2015 we engaged with local people and our health and care staff (around 8,000 people in total); we now have a very clear understanding of what things are like on the ground, and what people want our Partnership to focus on. This has provided a firm basis for our transformation work since then

CHANGE led by clinicians

Establishment of the Provider Alliance and support for clinicians to drive and lead change

GET KEY BUILDING BLOCKS IN PLACE NOW

View every step you take from now on as a building block to your vision of an Integrated Care System; start getting your joint commissioning in place etc. It will all come together eventually; this foundation work is key

BHR Integrated Care System next steps

Consolidation of our scoping/preparation phase:

- Restating of Integrated Care System vision and engagement with partners and stakeholders to socialise this
- Develop project plans for areas that we are working on to test the principles of Integrated Care (for example, frailty), including next steps for key system enablers such as IT, Workforce and Estates
- Conclude our governance review and take forward the recommendations; refine so that decision making can keep pace with the programme

Begin to move towards our delivery phase:

- Primary Care Transformation Board to build on achievements to date (including successful establishment of GP Federations and GP Networks) and continue to oversee Primary Care improvement workstreams
- Provider Alliance to continue to develop relationships and take a greater role in leading provider delivery at scale
- Progress to delivery of proposals described above
- Continued exploration of key enablers such as new payment mechanisms
- Continued engagement with local people and key stakeholders across BHR including the Community and Voluntary sector

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Q&A followed by table discussion and feedback

To discuss on your tables (and record key points to feedback)

Reflecting on the presentations you have just heard about building system leadership for integrated care:

- What is different in behaviours required?
- What would good look like?
- What are the barriers and enablers?
- What support would assist?

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Refreshment Break

Please return at 11.25

London Clinical Senate

Epsom and St Helier – Integrated Care

Dr Ruth Charlton and Dr James Marsh
Joint Medical Directors, Epsom and St Helier Hospitals NHS Foundation Trust

Epsom Health and Care

Dr Ruth Charlton

Dr James Marsh

Joint Medical Directors

Epsom and St Helier University Hospitals NHS Trust

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Overview

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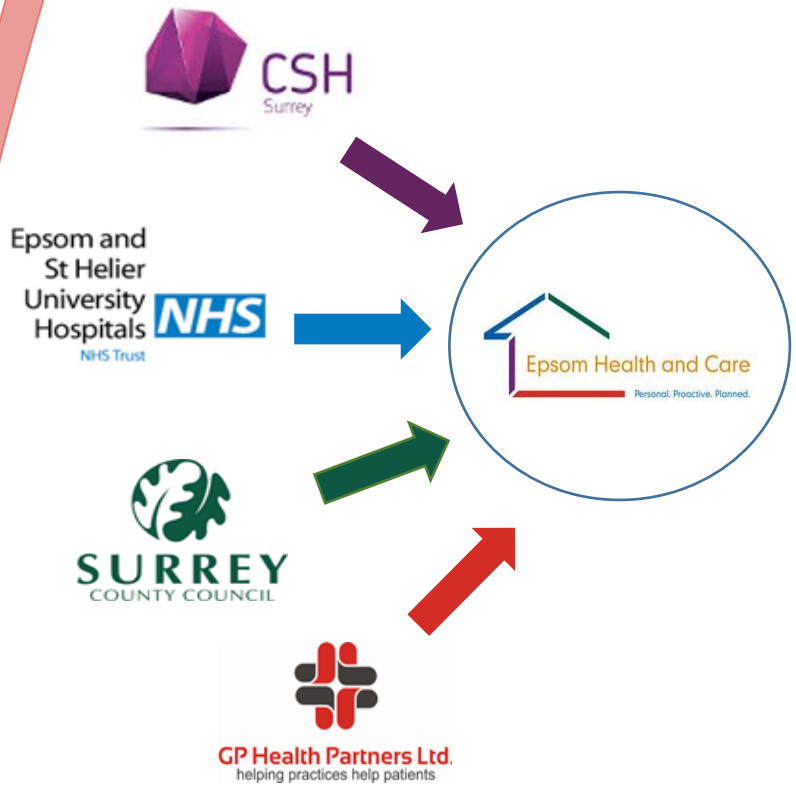
Local challenges mirror those encountered nationally

The CCG and providers decided to **reset** the structure we are working in

EHC was established in June 2016 as a joint venture



- Vision to provide coordinated and integrated care to the population 200,000 people registered 20 GP practices of GPHP (GP Federation)
- United by a shared interest in urgent and emergency care at Epsom General Hospital
- Drive to create a whole system approach, with the patient and carer at the centre of their care – care wrapped around the person not the organisation

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EHC holds an outcome-based contract which required new governance arrangements to be established

Consortium Agreement – All partners equal
Alliance Board with Independent Chair

Consortium Agreement between providers makes this a **Joint Venture** model not a Lead Contractor model

Legal agreement binds partners together and makes them **jointly accountable for delivery** of outcomes provision of quality services + the allocation of finances between partners and others

Financial risk sharing is based on establishment of a contingency fund and commitment to whole partner support if finances or targets are not achieved

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Epsom Health and Care @home service

Physicians, community matrons, nurses, social workers and others work together in a single team

Intensive, multi-disciplinary care packages help people stay at home

Single patient care plan and shared records facilitate integration between services and mean patients only need to tell their story once

@home currently provides integrated care

@home co-ordinated assessment and diagnostics service	**Enhanced @home (rapid response service and supported discharge service)**	**@home hub (coordinated care up to 12 weeks)**

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EHC is making a demonstrable improvement to care outcomes

More people have been receiving better care, at home…

- On average **3** patients remain at home and **2** brought home sooner each day
- Equivalent **1 ward** patient being actively looked after at home

People are receiving care in the right setting…

- **6% reduction in overnight NEL admission** for patients 65+ (17/18 comparison with 16/17
- Over **1700 patients** cared for in the community by the integrated team

New ways of working….

- Over **50 staff** now working for EHC across the acute and community
- **Co-design** is central to all we do
- **Lay Partners** are embedded and leading some programmes
- Clinicians work as **one integrated team**

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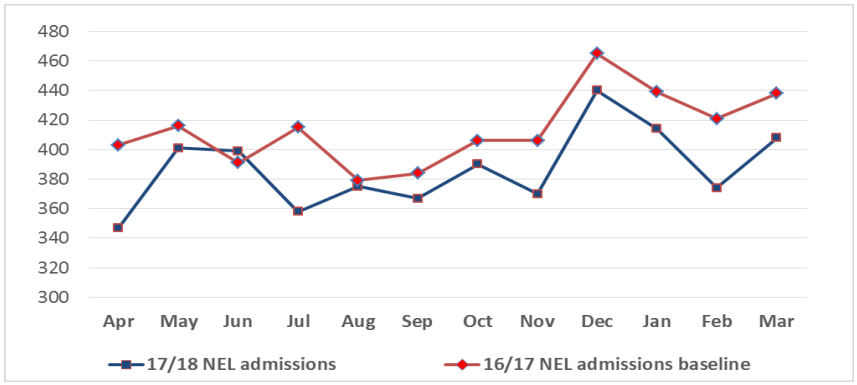
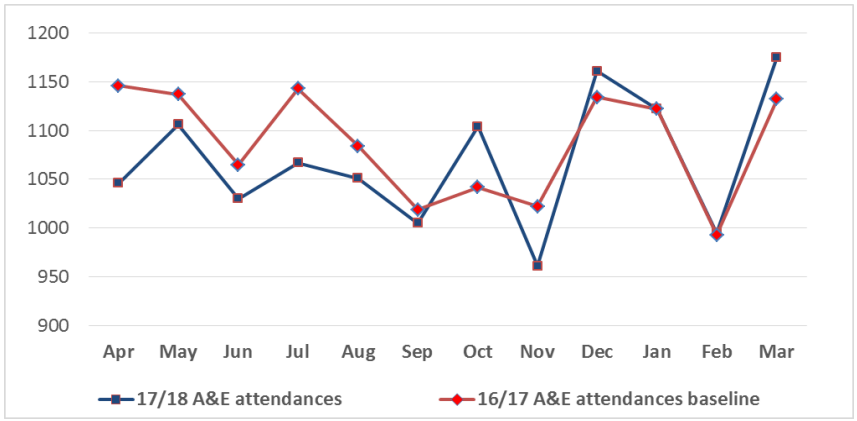
Epsom Health and Care has helped people spend less time in a hospital setting



Non elective admissions in 2017/18 **6% below** 2016/17 levels (compared to 6% increase on St Helier site)



More people receiving the urgent care they need in the community instead of having to go to AE

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Epsom Health and Care Approach

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Epsom Health and Care is built upon a set of a shared vision and values

Our Vision

"Transform people's experiences of care by being a leading provider of **integrated health and social care services**"

We will do this by putting people's needs first, so individuals receive **personal, proactive and planned services** that will keep them well, safe and living independently.

Our Values

Innovation
- ✓ Create new ways of caring
- ✓ Push beyond and remove boundaries and barriers
- ✓ Transform services

People Focused
- ✓ Empower and involve people
- ✓ Value everyone
- ✓ Offer choice

One-Team
- ✓ Work together
- ✓ Share knowledge
- ✓ Support each other

Safe and Effective
- ✓ Provide timely care
- ✓ In the best place for everyone
- ✓ Are well trained and provide consistent care

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How Epsom Health and Care works

…with local people with Lay Partners as equal partners in all of our governance

…through genuine co-design and co-production with users, carers, communities and our staff

…as one team irrespective of organisational employer –care wrapped round the person

… with a culture which values everyone's contribution in all we do and are

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Challenges and Enablers for Success

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What were our challenges?

“We already do all of that”

“Everybody wants transformation but nobody wants change”

“This is an acute trust take over”

“That’s not the way we do things in our organisation”

“It will never work”

“We should not involve staff and lay people until we know more”

What made it work?

- Clear visible system leadership across providers
- Clear articulated vision and message
- Enabling but clear governance
- Shared budget with shared decision-making
- Shared responsibility for performance
- Integrated care record / data sharing agreement

- But more importantly…

Governance is important but so is delivery

- ‘Learning through doing’ - start somewhere and go everywhere
- Build on principles of continuous learning
- Co-design with staff and lay partners
- Integrated teams – people see the team not the organisation
- Solution focused approach…….keep going

Building upon firm foundations

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Epsom Health and Care Personal. Proactive. Planned.

Integrated Care Partnerships

- ***IDEEA –*** Contractual Joint Venture across all Surrey Downs to Provide community Services

- ***SUTTON HEALTH AND CARE*** at Home Service started April. Expanding to all adult community services April 2019

NHS Epsom and St Helier University Hospitals NHS Trust

CSH Surrey

GP Health Partners Ltd. helping practices help patients

Sutton

NHS Epsom and St Helier University Hospitals NHS Trust

NHS Dorking Healthcare GP Federation

NHS Surrey Medical Network GP Federation

NHS South West London and St George's Mental Health NHS Trust

SUTTON GP SERVICES

CSH Surrey

Epsom and St Helier University Hospitals NHS Trust

SURREY COUNTY COUNCIL

GP Health Partners Ltd. helping practices help patients

Epsom Health and Care Personal. Proactive. Planned.

Questions?

London Clinical Senate

Working towards system leadership – Haringey and Islington Wellbeing Partnership

Rachel Lissauer
Director, Islington and Haringey Well Being Partnership
Dr Josephine Sauvage
Chair, Islington Clinical Commissioning Group
Beverley Tarka
Head of Adults and Health, London Borough of Haringey

Haringey and Islington Wellbeing Partnership

- Who we are
- Thoughts on system leadership and on leading within complex systems
- Observations from our experience
  - Recognising where we are seeing and showing system leadership
  - Recognising where we are not and some thoughts on why

Haringey and Islington Wellbeing Partnership

2 Boroughs and **2 CCGs**

488,000 resident population

529,000 registered with GP practices

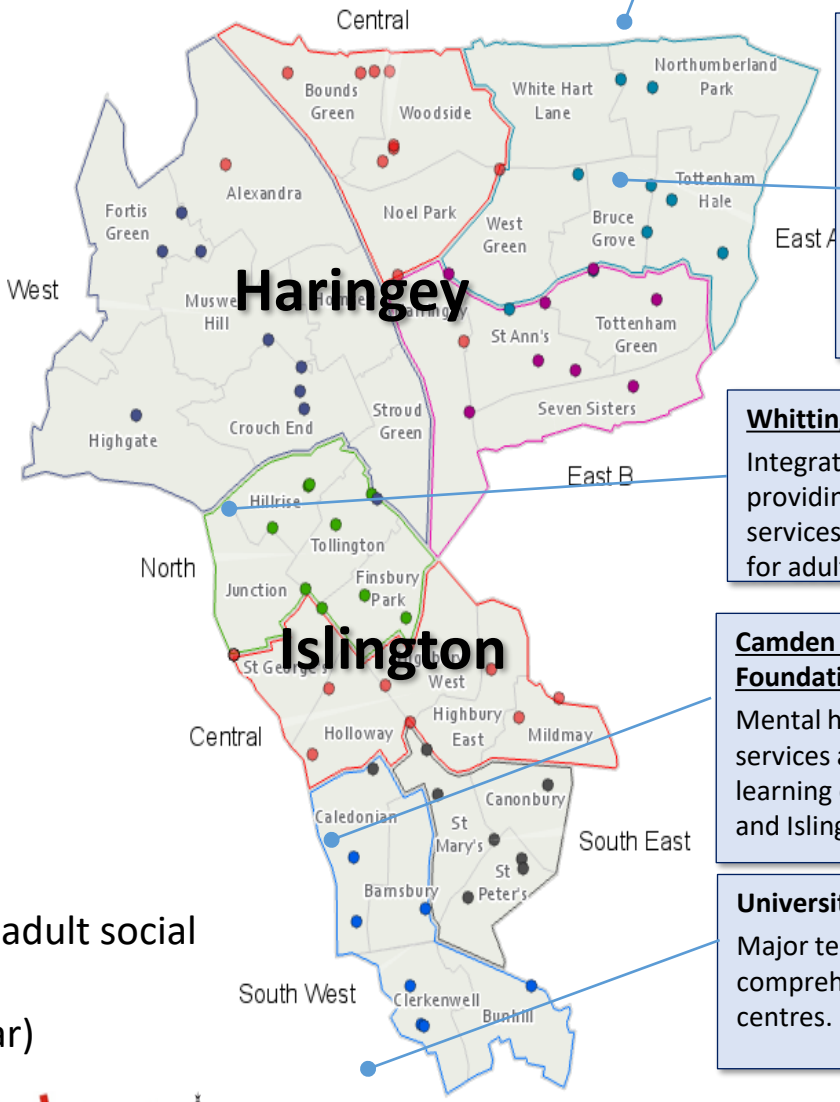
2 Mental health trusts

1 Integrated acute and community trust

2 Acute hospitals

60 GP practices across **2** federations

£931m
CCG & LA spend on health & adult social care
(c. £1,900 per person per year)



North Middlesex Hospital NHS Trust

Acute Trust serving Haringey and Enfield

Barnet Enfield and Haringey Mental Health NHS Trust:

Mental health services to people living in of Barnet, Enfield and Haringey, and a range of more specialist mental health services to a larger area

Whittington Health NHS Trust:

Integrated Care Organisation (ICO) providing acute and emergency services, community health services for adults and children

Camden and Islington NHS Foundation Trust:

Mental health, substance misuse services and care for people with learning disabilities across Camden and Islington

University College London Hospital:

Major teaching trust and one of five comprehensive biomedical research centres.

Islington Clinical Commissioning Group · Whittington Health · NHS Haringey London · Islington · Camden and Islington NHS Foundation Trust · Barnet, Enfield and Haringey Mental Health NHS Trust · NHS Haringey Clinical Commissioning Group

Young, diverse boroughs

Stark health inequalities

High working age populations

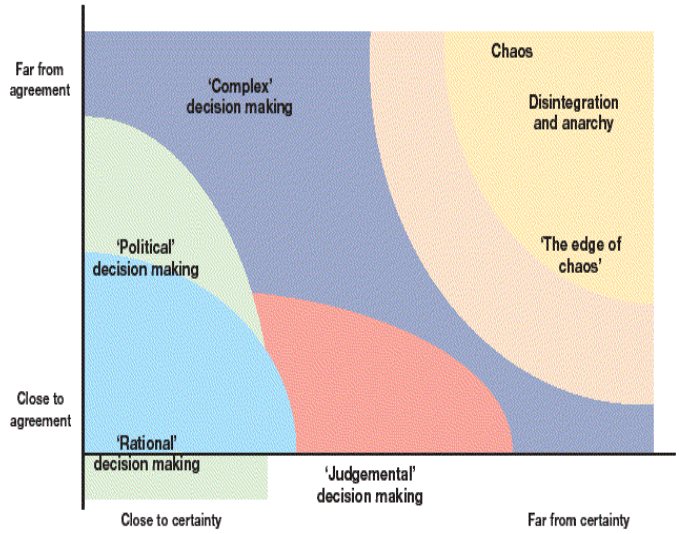
High numbers of working age people not working due to long term conditions

Opportunities: mental health and wellbeing, supporting people into employment; hypertension and cardiovascular disease

Date	Abridged timeline
Jan 2015	Haringey and Islington (H&I) councils, CCGs, Whittington Health and C&I FT worked together to submit a New models of care Vanguard bid (unsuccessful)
Mar - Jun 2015	Parties to the Vanguard bid agree to continue working together as part of a Haringey and Islington system. Sponsor Board and joint managers' Delivery Board established.
Nov 2015	H&I Transformation Retreat – understanding our local population and system as well as accountable care models
Mar 2016	Wellbeing Partnership update provided to H&I Health and Wellbeing Boards for approval Initial meeting with Haringey and Islington lead councillors to agree future support
Jul 2016	Priority areas for population based improvement agreed: MSK, Diabetes & CVD, Children and Young People, Intermediate Care, Mental Health, and Frailty
Sep - Dec 2016	BEH Mental Health Trust, UCLH, NMUH and Islington and Haringey GP Federations joined the Sponsor Board and Delivery Board New projects for Intermediate Care and Children & Young People added to the programme Haringey and Islington Health and Wellbeing Boards agree future plans to meet in common to support oversight and progress of the Wellbeing Partnership
Jun – Jul 2017	Wellbeing Partnership Agreement signed
Aug - Oct 2017	Care Closer to Home CHIN development in H&I becomes part of the Wellbeing Partnership Expanded Sponsor Board Workshop to establish next steps and programme plan for 2017/18
Feb 2018	Project team established

What we mean when we say system leadership

A recognition of complexity
A need to adapt leadership styles to reflect that we work within complex adaptive systems (i.e. multi-level, multi-agency systems)
Recognising that agents within systems are themselves adaptive, responding to each other and their environment
Systems adapt and change over time. The locus of control is often unclear.
Direction is influenced not set
Edge of chaos is the preferred state – where new thinking emerges, innovation is possible



In an unpredictable world it is futile to devise elaborate plans to reach specific outcomes. Establish a set of principles:

"capture the high ground, stay in touch, and keep moving" (US Marines)

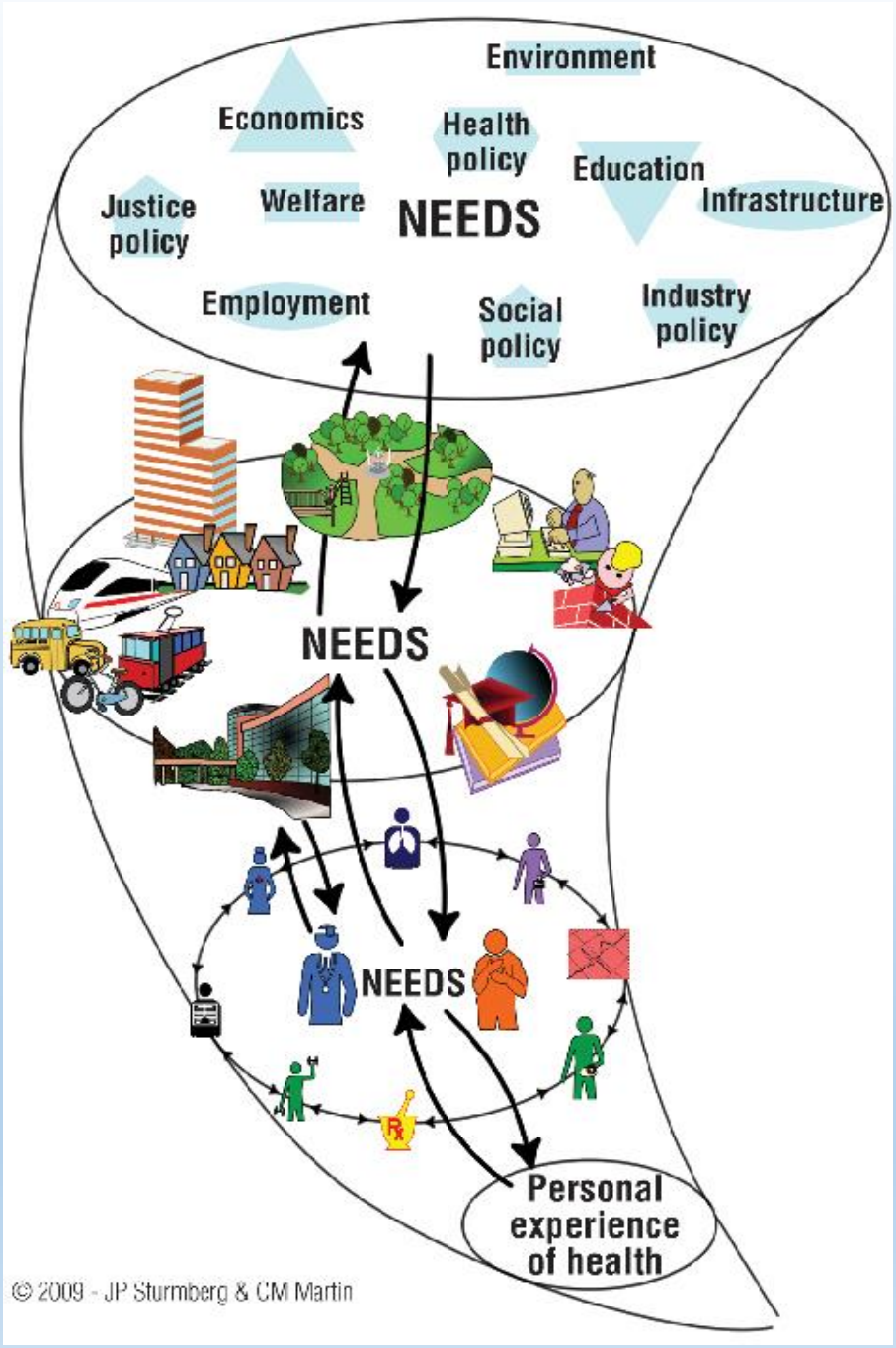
And in healthcare?

Traditional management approaches in health	Recognising complexity in health management
Views organisations as machines	Relationships between the parts are more important than the parts themselves
Rigid specification of individual component parts	Focus on outcomes – allow for creativity
Battle resistance to change	Understand motivators, build on past experiences

Leading us to think about:

- Characteristics of system leaders (Mandela in truth and reconciliation, Che Guevara rather than Stalin)
- Approaches and techniques in leading across systems
- What happens when 'edge of chaos' collides with rigid bureaucracy…

Plesk and Wilson 'Complexity, leadership, and management in healthcare organisations' BMJ 2001;323:746–9



System working should help us to nudge at all levels

Working across organisations, agencies and communities to create the conditions for innovation and for choices that support health improvement

Jobs
Schools and education
Housing
Transport
Building and planning

Communities that support individuals

Offer services that are networked and connected

Support positive health and wellbeing

At a Glance: The Haringey and Islington Wellbeing Partnership Strategy

Born well, live well and age well in Haringey and Islington
Supporting people to stay well in mind and body
Connecting health and care services around the needs of the person
Quick access to high quality services

To deliver our vision we have agreed 8 partnership commitments:

1. One ambition
2. One strategy
3. One financial plan
4. One delivery team
5. One set of behavio
6. One set of outco
7. One governance
8. One transformation approach

In 2018/19 we will demonstrate these commitments by delivering a new model of care:

Integrated health and care networks

Bringing together mental and physical health and social care practitioners to provide population-based health and care, centred on communities

Improving care for people with and at risk of diabetes *mental and physical wellbeing, fewer complications, able to self-manage and a positive experience of*

Improving lives for people with frailty *maintaining independence, social contact and good health, early and coordinated help, rapid access to support when needed*

Improving intermediate care *Timely, high quality and coordinated care to prevent crisis and support recovery*

MSK services transformation *Quick access to a joined up service for all 'non-emergency' MSK adult health and care services in primary, community and secondary settings*

Improving care for children *Improving community services and care outside hospital for children to ensure that every child has the best start in life*

Improving mental health *supporting people and communities to manage their wellbeing and mental illness close to home and integrating with other services*

This transformation will be underpinned by these essential enablers:

System Leadership
- Taking the steps to deliver the vision
- Encourages and empowers teams to bring ideas to life
- Processes need to reflect the culture they are trying to build

Governance
- Structure that provides strategic direction and delivers against agreed mandate
- Ensuring the proper representation and political support for the partnership

Joint commissioning and aligned incentives
- Shared understanding of our partners' financial positions and collective agreement about their use
- Contracting mechanisms appropriate to our strategy

Workforce
- A 'place-based' workforce co-located around the networks
- Vertically Integrated professional development
- An OD focus on relationships and values between people, teams and communities

Estates
- Single estates strategy with common principles in estates decision making
- Align incentives across partners
- Agree and prepare a capital priority list to ready to respond to the availability of capital

IT
- Digital integration with systems deployed efficiently
- Patients activated and engaged with care record
- Data driven insights from across health and social care

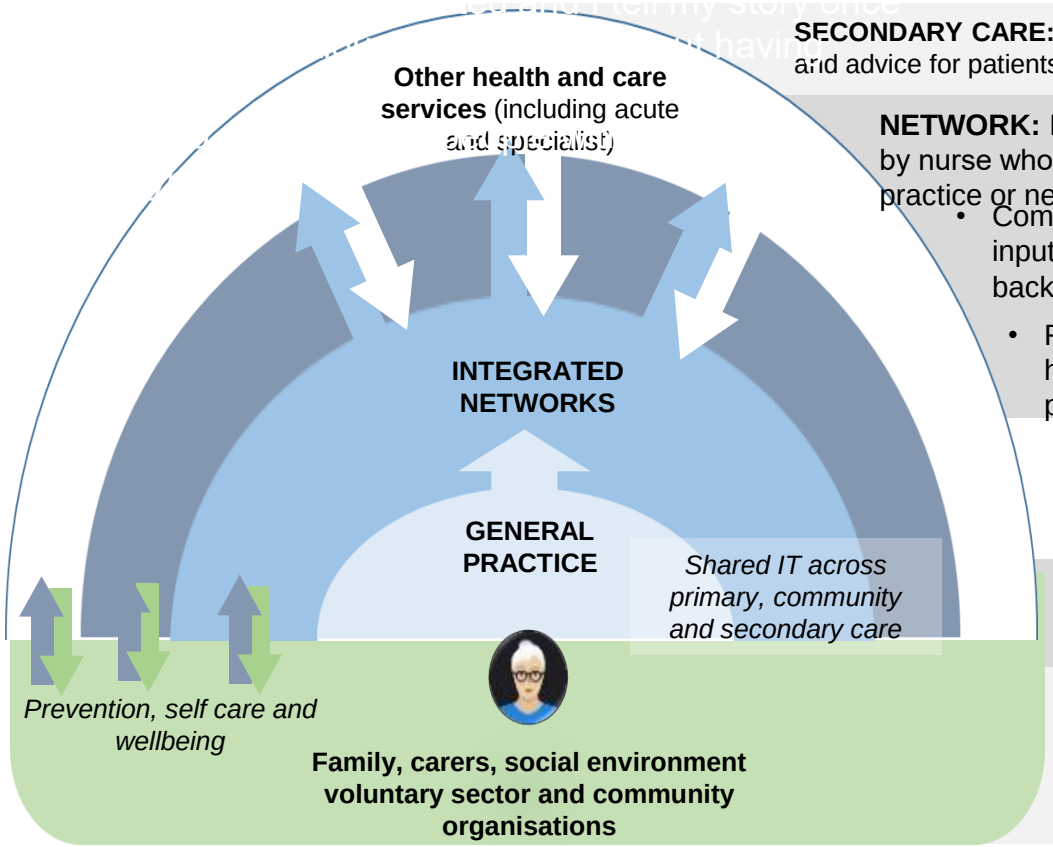
SYSTEMS WITHIN SYSTEMS A networked approach to diabetes – GP, network, integrated specialist pathway

Intended system outcomes

- Achieving 3 treatment targets: BP, cholesterol, blood sugar
- "I am able to stay well. I am confident and able to manage my condition"

Longer term:

- Reduction in residential care packages
- Reduction in strokes, heart attacks and amputa



SECONDARY CARE: A consultant led team for specialist care and advice for patients with complex care needs in hospital

NETWORK: Initial extended assessment for patient by nurse who works across network in patient's own practice or nearby

- Complex patients taken to MDT with input from secondary care and refer back to GP when care plan is in place
- Feedback and skilling up practice on how to manage more complex patients

easy e-referral, telephone or face to face discussion

GENERAL PRACTICE provides a consistent level of quality care and advice

PREVENTION – proactive interventions for ongoing care needs delivered in the community, including exercise groups, walks, blood pressure testing and local area co-ordinators.

Improvement in population level outcomes

Holistic review and access if required to:

- Care navigator
- Dietitian
- IAPT
- PH Needs/One You
- Intermediate Diabetes Service
- Podiatry Service
- Social worker
- Diabetes Self Management Programme
- Diabetes Consultants (MDT)

Potential referral criteria to enhanced support:

- Maximal oral therapy and HbA1c over 7.5
- Foot problems
- Psychological symptoms (screening tools)
- Uncontrolled blood pressure
- Other concerns

Attributes of system leaders

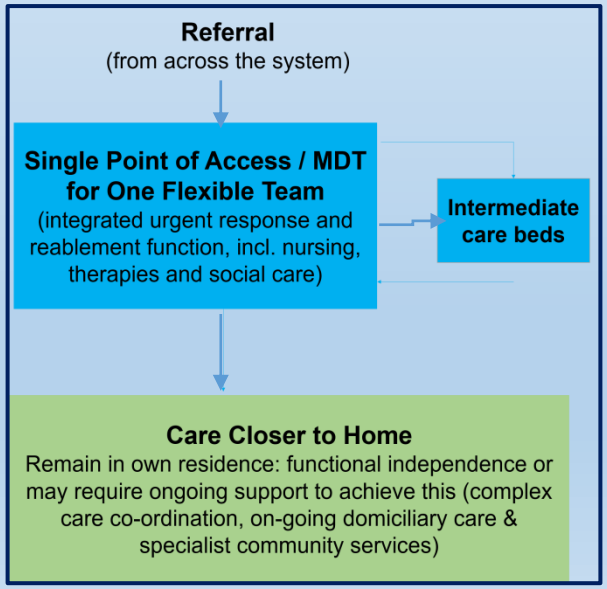
- Able to see the wider system and see the world from the perspective of others
- Foster reflection and generative conversations - shared reflection is a critical step in enabling groups of organizations and individuals to actually “hear” a point of view different from their own, and to appreciate emotionally as well as cognitively each other’s reality.
- Shifting the collective focus from reactive problem solving to co-creating the future. Change often starts with conditions that are undesirable, but artful system leaders help people move beyond just reacting to these problems to building positive visions for the future. This typically happens gradually as leaders help people articulate their deeper aspirations and build confidence based on tangible accomplishments achieved together. This shift involves not just building inspiring visions but facing difficult truths about the present reality and learning how to use the tension between vision and reality to inspire truly new approaches.

What we have learnt

Approaches that have supported system leadership

- Systems mapping – beyond our organisations
  - Discharge 2 Assess – wards, discharge teams, social care, community nursing, reablement, care homes
  - Childhood asthma - schools, primary care, community, hospital
- Fitting payment structures around services (D2A)
- Peer shadowing, learning journeys (MSK, community services)
- Shifting from problem solving to creating solutions, allowing teams space and facilitating their ambitions (intermediate care)

Change happens in here, not out there



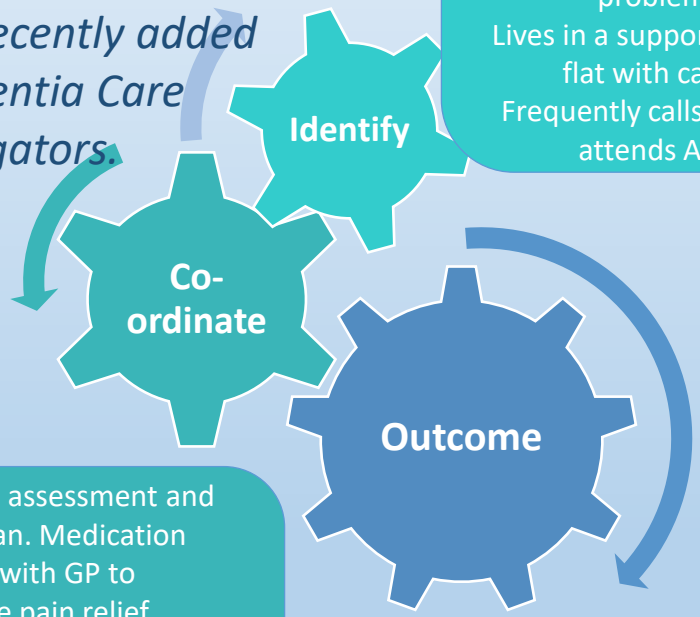
System leadership is still very difficult:

- When, within the NHS, we are working against national incentives, priorities, behaviours and frameworks
- When we are not recognising complexity and still try to lead it all ourselves rather than engaging with people and communities
- When we have not created the right conditions for innovation – insufficient capacity
- When all organisations hold deficits and have limited freedom to share risk
- When there is ambiguity about ‘the system’ – borough, bi-borough, sub-borough
- Where structures do not support system working – e.g. individual management teams, statutory responsibilities, opaque budgets

And yet...

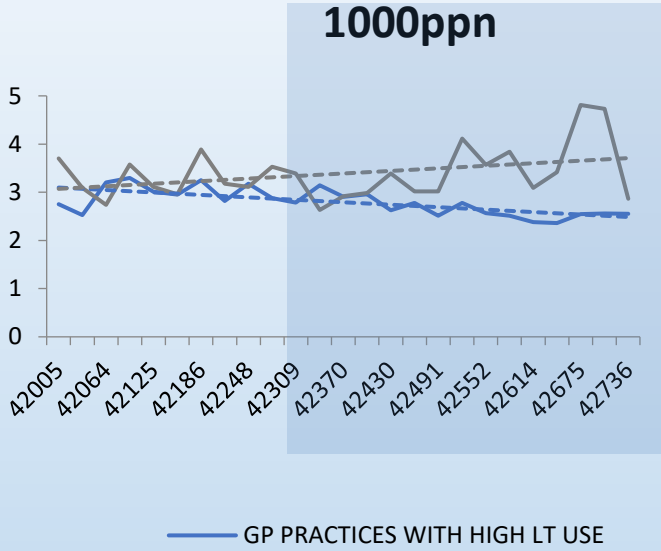
Team around the person: A Physiotherapist, Pharmacist, Social Worker, Community Mental Health Nurse and the recently added Dementia Care Navigators.

Mrs M, 76 year old
Referred by GP
Mobility significantly impaired due to fall and hip replacement
Complex history with physical and mental health problems
Lives in a supported living flat with carers
Frequently calls 999 and attends A&E



Holistic assessment and care plan. Medication review with GP to improve pain relief
Liaison with mental health and befriending services.
Education and alternative support for emergencies

18-64 patients rate of Non Elective admissions per 1000ppn



"A patients that would previously have needed a referral to two or more of these agencies is now assessed by a pair from this group, their needs assessed and provided for by the team working together and in with close liaison with ourselves and via the Telephone Multidisciplinary Conference with the (fantastic) Care of the Elderly Team at The Whittington.

No longer are there delays waiting for a community physio assessment, who then recommends a referral to social services, who then recommends a psychiatric assessment, with ourselves being unsure what stories have been collated, and who is providing what". An Enthusiastic GP

London Clinical Senate

Patient-clinician collaborative pairs: finding ways to integrate as equals

Oonagh Heron and Ellen Sykes

London Clinical Senate

Q&A followed by table discussion and feedback

To discuss on your tables (and record key points to feedback)

Reflecting on the presentations you have just heard about building system leadership for integrated care:

- What is different in behaviours required?
- What would good look like?
- What are the barriers and enablers?
- What support would assist?

London Clinical Senate

Panel reflections – key thoughts and advice from today

Richard Ballerand
London Clinical Senate Patient and Public Voice Group Member
Samira Ben Omar
Head of Systems Change, Integrated Care System, North West London Collaboration of Clinical Commissioning Groups
Julie Lowe
Programme Director, South East London STP
Anatole Menon-Johansson
Clinical Lead for Sexual Health, Guy's and St Thomas' NHS Foundation Trust
Beverley Tarka
Head of Adults and Health, London Borough of Haringey
Jane Wilson
Medical Director & Consultant Obstetrician & Gynaecologist, Kingston Hospital, NHS Foundation Trust

London Clinical Senate

Closing remarks: how today's outputs will be used

Dr Vin Diwakar
Medical Director, NHS England London Region
Clinical Senate Forum Co-Chair

London Clinical Senate

Close

Next London Clinical Senate Forum date:
11th October 2018