Transforming Services Together

Strategy and investment case

Part 3: High impact changes
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About this document

This document is part 3 of the Transforming Services Together *Strategy and Investment Case*. It contains a detailed analysis of the thirteen initiatives which form the core of the Transforming Services Together programme.

It should be read in conjunction with parts 1 and 2 of the *Strategy and Investment Case* document. If you do not have a copy, please contact the Transforming Services Together team on:

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Website: www.transformingservices.org.uk

Risk rating methodology

The following methodology has been used to score the risks associated with the practical delivery of the changes suggested in sections 1 to 13 of this document.

![Risk rating methodology table]

Ranges and sensitivity analysis

As part of the work to understand the financial impact of the proposed changes, we carried out sensitivity analysis of the changes that the system will make.

This helped identify the key variables that potentially impact positively or negatively on the net savings position through a risk assessment of the key assumptions, resulting in upper and lower ranges for the key changes we are making.
1: Expand integrated care to those at medium risk of hospital admission

1.1 The case for change

Integrated Care initiatives have been designed as part of the Transforming Services Together (TST) five year planned response to the health issues in East London highlighted by the Integrated Care Case for Change, published in December 2012\(^1\) and the Transforming Services Changing Lives (TSCL) Case for Change, published in December 2014\(^2\).

Whilst the TSCL Case for Change had a particular focus on hospital services, the diverse nature of the population in East London presents broader health and social care pressures and implications that reach into primary care, social care, community services and the third sector. TST as a programme of work therefore encompasses this broader consideration of issues. More specifically, the TSCL Case for Change identified a need to improve and strengthen our integrated care approach and this is being achieved through redesigning the way services work and by providing improved primary and community care through better care planning.

The proportion of over 65s in East London is expected to grow faster than other age groups

The TSCL Case for Change identified a pressure point in the East London population as it will experience the highest proportional increase in its population among over 65s compared with the rest of London. This group are likely to live longer, and suffer more long-term conditions which would require more complex care\(^3\). A more coordinated approach to care is about building a model of care that looks at the whole person, focusing on patients with long-term conditions, the elderly and people with mental health problems. By adopting these principles in a model of care, pressure points on the future East London health system, such as an aging community, can be better responded to.

The East London area continues to be committed to embedding a consistent model of integrated care, with initiatives beginning in 2013. The Integrated Care Case for Change called for “higher-quality, more efficient and joined up care in East London”\(^4\). An integrated care model aims to shape care provided around the needs of the patient, rather than organisational, service and borough boundaries. This will improve quality, efficiency and patients’ experience of care as well as achieve the integration across service providers – GPs, hospitals, community services and the third sector – that is necessary to join-up the various components of a patient’s care journey.

Twenty percent of East London patients account for 80% of the healthcare costs

Analysis from the Integrated Care Case for Change integrated dataset (combining data at a patient level across health, social, mental, community and primary care) was risk stratified based on a patient’s likelihood of hospital admission. It showed that around 20% of patients

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1 Integrated Care Case for Change - Summary, WELC 2012
4 Integrated Care Case for Change - Summary, WELC 2012
account for 80% of healthcare costs. This top cohort of patients often receive the most fragmented care. Therefore, integrated care services in East London have targeted this part of the population (see diagram below), further divided into very high risk (VHR) and high risk (HR) (c.5% of the population), and have commenced extending the approach to the moderate risk (MR) cohort (c.15%) from 2015:

Risk stratification of the East London population and associated healthcare costs

![Risk stratification diagram](image)

Source: TST Case for Change Summary, 2012

Some integrated care initiatives have been in place in East London since 2013, and at this stage have targeted the VHR and HR cohorts with plans to ramp up to reaching the full 20% of the population by the end of the five year plan (2020/21).

One of the key findings of the TSCL Case for Change is that hospitals cannot secure high-quality and financially sustainable services on their own; the successful implementation of integrated care is expected to reduce emergency admissions, emergency department attendances, readmissions, and associated elective care provision through better ways to coordinate care. The potential reduction in non-elective spend is estimated to be 24-40%, based on variability between GP practices across the boroughs, a comparison of East London performance against Office of National Statistics (ONS) top performers and a review of the global evidence base on integrated care. This reduction in spend will deliver benefits in terms of reducing the number of occupied bed days relating to the integrated care patient cohort. At this stage, as integrated care interventions are implemented and embedded, the estimated impact has been modelled at lower rates. As schemes mature and new ways of working between providers to coordinate care and improve patient outcomes are realised, the potential impact on non-elective spend may be expected to increase.

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5 Integrated Care Case for Change - Summary, WELC 2012
7 Integrated Care Case for Change - Summary, 2012, slide 2
Future ambitions

Over the next five to ten years integrated care will reach beyond the 20% of the East London population most at risk of hospital admissions, as we move towards maturing integrated care approach and initiatives across the region with the overall aim to scale up to ‘business as usual’ and whole systems working in line with overarching ambitions, and expanding services in the community as appropriate.

This will be delivered by integrated provider networks that are strengthened by interoperability, improved care pathways and shared care planning – ensuring improved patient experience, improved health outcomes and improved system efficiencies.

We will deliver care that is integrated for a fully risk stratified East London population that would cover:

- case management for the VHR and HR cohorts
- care coordination and navigation for the MR cohort
- self-care/self-management for Low Risk (LR) and Very Low Risk (VLR) cohorts.

1.2 Model of care

Integrated care plays a part in achieving system-wide transformation and partnership. The East London area aspires to build a system of coordinated care that empowers patients, provides more coordinated, proactive and responsive care, and ensures the system operates in an efficient and consistent manner.

To achieve this, East London has designed a new model of care with nine key interventions for its population, which are underpinned by enablers and components:

Model of integrated care across East London

<table>
<thead>
<tr>
<th>Areas of interventions</th>
<th>Enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care, behaviour, and expectation management</td>
<td>Organisational Development</td>
</tr>
<tr>
<td>Care Planning</td>
<td>• GP networks</td>
</tr>
<tr>
<td>Health and social care navigation</td>
<td>• Clinical leadership</td>
</tr>
<tr>
<td>Case management</td>
<td>• Integrated provider networks (inc. third sector)</td>
</tr>
<tr>
<td>Specialist input in the community</td>
<td>• Contracting and reimbursement models</td>
</tr>
<tr>
<td>Discharge support for mental health patients from secondary to primary care</td>
<td>Workforce</td>
</tr>
<tr>
<td>Rapid response with short team reablement</td>
<td>• Creation of new roles – case manager, hybrid health &amp; social worker, health &amp; social care coordinator, discharge coordinator (based in acute wards)</td>
</tr>
<tr>
<td>Mental health liaison</td>
<td>Communications</td>
</tr>
<tr>
<td>Discharge support from acute to community</td>
<td>• Whole system</td>
</tr>
<tr>
<td></td>
<td>• Patient engagement</td>
</tr>
<tr>
<td></td>
<td>Informatics</td>
</tr>
<tr>
<td></td>
<td>• Information sharing and decision support</td>
</tr>
<tr>
<td></td>
<td>Estates</td>
</tr>
<tr>
<td></td>
<td>• Capacity in the community</td>
</tr>
</tbody>
</table>
This new model of care\(^9\) has been developed as a co-designed approach to ensure that:

- **Care plans** are developed around the needs of the patients at highest risk of hospitalisation
- **Discharge planning** is coordinated between health and social care services
- **New ways of working** are put in place that join up services and better support people in their own homes
- **Technology** is put to better use and information shared securely so that staff have information about the right person at the right time in the right place
- Commissioning approaches **incentivise** joint working and preventative care
- Patients are given the support they need to **stay well** through prevention and **self-care** management interventions
- All health and social care organisations work together to meet the needs of their patients

**Developing integrated care for people at moderate risk of hospital admission**

As integrated care is extended to those at moderate risk of admission, the interventions and services required to support patients are expected to diversify, with an increasing focus on **secondary prevention** and **self-care**. By building capacity in settings such as primary care (please refer to ‘Model of Care’ in the primary care initiative - part 3, section 4) and in the third sector, the medium risk cohort will be able to access care that will reduce the demand on acute services. This also means service users will experience coordinated, high quality care in community-based settings and be better supported by a well-developed and engaged multi-disciplinary health and social care.

Please see below for diagram of East London Care Closer to Home / Integrated Care programme showing timeline, model of care and intervention against risk-stratified East London population.

**Enablers**

Integrated care delivery will be supported by several key enablers which are also shared across other workstreams of TST, including care closer to home schemes. In particular, the IT enabler is key to realising care integration via the development and implementation of informatics interoperability and shared care records access across providers to give improved experience of care and coordinated care for service users. Another key enabler is organisational development in regards to facilitating clinician, staff and care provider the necessary culture change for joint and new ways of working to achieve directing care for patients in the most appropriate setting. More details are given in part 2, chapter 3.2 of the **Strategy and Investment Case**.

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\(^9\) Model of Care for Integrated Care across WEL, IC Commissioning Intentions 2016/17
East London Care Closer to Home / Integrated Care Programme 2012-2021

Timeline

2012

Maturity reached over 5-10 years

Developing New Models of Care

Integrated Health and Social Care Organisations

GP Federations

Primary Care

Community

Secondary Care

Mental Health

London Borough

Third Sector

Integrated Health and Social Care
Provider Networks / Organisations (MCP, ICO etc.)

2021

Timeline Developing New Models of Care

Integrated Health & Social Care Approach

Population Segmentation/Risk Stratification

Areas of Intervention

Care Co-ordination

Ensuring people are in the most appropriate setting of care

Self-Care

Very High Risk (0.5%)

High Risk (4.5%)

Moderate Risk (15%)

Low Risk (30%)

Very Low Risk (50%)

- Person-centred care including information personalised advice and education
- Community-based approaches to increase local choice and support, community volunteering for health inc. Social Prescribing
- Enabling approaches e.g. digital engagement and enablement

- Care planning
- Health and social care navigation
- Case Management
- Specialist input in the community
- Discharge support from acute to community
- Rapid response with short term reablement
- Discharge support for MH pts from secondary to primary care
- Mental Health liaison
- Discharge support from acute to community

Source: WEL IC PMO, 2015
1.3 Engagement

Engagement has been extensive including clinicians and patient representative groups. The table below lists the examples of engagement across the integrated care themes and the forums in which this has taken place:

<table>
<thead>
<tr>
<th>Borough level engagement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Governing Body Meetings</td>
<td>• Clinicians and patient representatives are present in the three borough CCG Governing Body meetings that occur monthly and include consideration of agenda items on integrated care work/developments at local level.</td>
</tr>
<tr>
<td>Integrated Care Committee</td>
<td>• Clinicians and patient representatives are present in the three borough Integrated Care Committee Meetings (also named Integrated Care Board and Better Care Fund board) that occur monthly and report on agenda items specific to borough level integrated care development based on this model of care</td>
</tr>
<tr>
<td>Waltham Forest Health and Social Care Leadership event (September 2015)</td>
<td>• Event included patient, clinical, commissioning, provider and Voluntary and Community Sector (VCS) involvement, and identified the need to take the intent of system-wide working into practice by adopting five key areas of focus; a provider partnership group and leadership project group will be established to take forward work on these key areas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrated care engagement by theme</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care planning and multidisciplinary team working</td>
<td>• Three of four workshops have been held on an East London-wide basis, involving service users, GPs, community and acute clinicians, social care professionals and commissioners from across East London. The workshops have developed a collective view of the process of care planning, the content of care plans and the roles and responsibilities required for successful care planning. A fourth workshop is in development following feedback from delegates to deliver an agreed East London-wide care plan template.</td>
</tr>
<tr>
<td></td>
<td>• Newham CCG ran two workshops with clinical, patient and commissioning involvement to specifically review multidisciplinary team (MDT) meetings – current practices and what they can be in the future. An outcomes paper has identified a new co-designed model detailing a core membership, frequency, objectives and outcomes for MDTs. Tower Hamlets and Waltham Forest had already completed similar review work on their MDTs. Recommendations included adoption of overall MDT principles and approach across East London, with borough-specific details due to the variances in care needed between them.</td>
</tr>
<tr>
<td>Capitation</td>
<td>• Waltham Forest held an engagement event at a Governing Body meeting (June 2015) outlining progress with capitation and</td>
</tr>
</tbody>
</table>
requirements of providers in preparation for shadow capitation in April 2016.

Evaluation

Interviews were carried out in March and April 2015 by Dr Laura Eyre, Researcher in Residence with the WEL Integrated Care programme which is being deployed in 4 phases. Almost 100 people attended from across East London, including front line staff and clinicians. The event included interpretive discussion sessions with executive and managerial level stakeholders from commissioners (including GPs), NELFT, ELFT, Tower Hamlets Integrated Provider Partnership (THIPP), and Barts Health.

Findings from phase 1 have fed into THIPP’s development of Value Proposition strategy; Newham MDT workshops; ELFT’s integrated care strategy; WEL Integrated care project plan; MDT development work in Tower Hamlets and Waltham Forest; care planning work and communications strategies. Findings will also be made available on the East London Integrated care communications web portal\textsuperscript{10} and have been made available to provider organisations for further sharing and use.

1.4 Outcomes the change will achieve

The integrated care model of care is intended to achieve the following outcomes:

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of care</td>
<td>• A more enabling, person-centred experience of care including more choice and greater satisfaction</td>
</tr>
<tr>
<td></td>
<td>• Provide personalised care through care navigator/care manager, working with people at higher risk of hospital admission to discuss their needs and care options, and plan their care in order to deliver seamless health and social care</td>
</tr>
<tr>
<td></td>
<td>• Provide joined-up care through improved IT interoperability, by integrating care providers via the person’s care plan and shared care record, limiting duplication of effort in situations where patient is seen by multiple health and social care providers</td>
</tr>
<tr>
<td></td>
<td>• Provide people with long-term health problems with better support to manage their own illness</td>
</tr>
<tr>
<td>Health outcomes</td>
<td>• Increase in years of life, reflected in the slope index\textsuperscript{11}</td>
</tr>
<tr>
<td></td>
<td>• Improvement in long-term condition rates e.g. diabetes, stroke, obesity, coronary heart disease, chronic obstructive</td>
</tr>
</tbody>
</table>

\textsuperscript{10} http://welccc.nhs.sitekit.net/  
\textsuperscript{11} http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Slope/SlopeIndexCharts.aspx
<table>
<thead>
<tr>
<th>Pulmonary disease, through implementation of self-care and prevention initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improvement in self-care/self-management (indicated by Patient Activation Measure (PAM)\textsuperscript{12} for self-care/self-management)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>System efficiencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demand management, including prevention and delayed escalation to higher support or service needs</td>
</tr>
<tr>
<td>• A reduction in emergency department attendances, and fewer admissions and readmissions to hospital (reduction by 20% in non-elective spend)</td>
</tr>
<tr>
<td>• Better and more appropriate utilisation of acute services by the VHR and HR cohorts by limiting the number of avoidable hospital admissions overall</td>
</tr>
<tr>
<td>• More efficient use of services, settings and staff because people would be treated in the best setting for their needs.</td>
</tr>
<tr>
<td>• Access to IT and information systems and using shared care records will ensure most effective use of clinical time and resources</td>
</tr>
</tbody>
</table>

Outcome improvement trajectories across the three boroughs will be agreed further to a review of the impact of integrated care interventions by stakeholders including commissioners, public health, patients, providers including acute, community, mental health and third sector.

1.5 Investment costs

In order to implement the model of care, capital and revenue investment is required. This is a shared investment that is not specific to integrated care, and is captured as part of overall Care Closer to Home costs. Please see Strategy and Investment Case part 2, chapter 3.2 for more details.

1.6 Impact on activity and revenue including sensitivity analysis

Integrated care is aimed at reducing unnecessary hospital admissions for those most at risk of requiring acute inpatient care, and will then mature into broader areas encompassed by better coordinated care working across providers in East London. It is a live programme (initiated in 2013) that has seen two/three years of savings already i.e. reductions in acute spend across the identified VHR and HR cohorts. This is a gradual reduction over time. With the extension of the programme to include the MR cohort, this will further reduce acute activity.

Shifting activity

Integrated care initiatives will not entirely remove hospital admissions of VHR and HR groups of the population, as there will always be people in the community that require this

\textsuperscript{12} \url{http://www.insigniahealth.com/products/pam-survey}
acute care. Yet the initiatives should ensure that it is patients with the most need of hospital admission that are admitted, rather than those that could receive care in more appropriate places outside of the acute setting.

The extension to include the MR cohort in integrated care initiatives also performs a preventative function whereby care plans are instigated for this group enabling earlier detection and better education around potential long term conditions for those at moderate risk of developing them, and potentially preventing these patients from moving up into the HR and VHR cohorts in the future.

Modelling has shown that the impact of integrated care interventions by 2020/21 results reduction of emergency bed days by 21,053 at Barts Health sites, as set out in the graph below.

**Effect of TST integrated care scheme on Barts Health emergency admission bed days**

The activity is re-provided via care closer to home schemes e.g. shifts into GP and community health services and the third sector. The capacity would provide Barts Health with the opportunity to tackle its backlog – or to treat other patients on the waiting list more quickly. More work is needed to understand the best use of this capacity for patients and the health system overall.

**Financial impact of activity shifts including sensitivity analysis**

After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £4.2m to £6.6m over a five year period.

**Integrated care assumptions**

The reductions illustrated in the financial impact commentary are modelled on the basis of the Quality, Innovation, Productivity and Performance (QIPP) submissions for Newham and Tower Hamlets, and reflect a 20% reduction for Waltham Forest (applied to the VHR, HR and MR non-elective admissions)\(^\text{13}\).

**Non-elective Admissions**

Newham and Tower Hamlets CCGs

\(^\text{13}\) TST Modelled Initiatives Summary Pack, V5 Run 7. December 2015, slide 65
The Healthcare Resource Groups (HRG) associated with this activity were identified and the relevant proportions of each HRG were removed from the TST activity/finance model.

The activity shifts were split based on the risk grouping of the patients.

Waltham Forest CCG

- The number of patients admitted in 2014/15 by HRG and risk category was identified.
- A 20% reduction was applied to the VHR, HR and MR non-elective admissions.

**Emergency departments**

For all East London CCGs, reductions in emergency department attendances were applied at a ratio of one attendance for each non-elective admission.

**Outpatients**

For all East London CCGs, reductions in outpatient attendances were applied at a ratio of 0.5 firsts and 0.5 follow ups for each non-elective admission.

**Integrated care phasing**

The reductions for the VHR and HR cohorts have been phased, based on the phasing included in the QIPP returns, which showed a 75% effect in 2015/16 and a 96% effect by 2016/17, before showing a full effect of the reductions from 2017/18 onwards. For the moderate risk cohort, the reductions have been phased to show 50% of the reductions occurring in 2016/17 and 100% occurring from 2017/18 onwards.

1.7 **Delivery risks**

The following risks and issues have been identified as the most critical (red RAG)\(^\text{14}\) to the overall East London integrated care programme; the actual risk levels vary between boroughs, to reflect local circumstances.

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organisational development (OD)</strong></td>
<td></td>
</tr>
<tr>
<td>Provider collaborative development does not happen at sufficient pace in each borough</td>
<td>Investment being made in GP networks and provider networks in all three boroughs. Progress at different stages. Further investment through Pioneer and Vanguard national teams. Also, sharing of local, national and international experience/good practice through Programme Management Office (PMO).</td>
</tr>
<tr>
<td>Organisational development needs are not prioritised by CCGs and provider partners, including local authorities</td>
<td>CCG sign off on <em>Strategy and Investment Case</em> which includes significant OD investment. Providers, particularly Barts Health to commit to investment in transformation (OD) as part of TST strategy</td>
</tr>
</tbody>
</table>

\(^{14}\) For a definition of risk ratings, please see part 3 ‘About this document’, p3
<table>
<thead>
<tr>
<th>Issue</th>
<th>Rationale or Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public, third sector and patient engagement in integrated care is lacking</td>
<td>Rationale for involvement articulated in <em>Strategy and Investment Case</em> in terms of added value and patient/health benefits and mandated to all partner organisations.</td>
</tr>
<tr>
<td>Lack of clinical engagement and leadership</td>
<td>Programme of investment in clinical leadership included in <em>Strategy and Investment Case</em>. As necessary, external expertise brought in to facilitate development.</td>
</tr>
<tr>
<td>IC deliverables are not articulated e.g. care co-ordination, patient experience, health outcomes, system efficiencies, preventing effective evaluation of outcomes to demonstrate impact of IC programmes/interventions</td>
<td>Benefits described in <em>Strategy and Investment Case</em>; detailed analysis of anticipated impact of IC care models to be reviewed by clinicians, patients, third sector etc., coordinated by public health.</td>
</tr>
<tr>
<td>Providers do not have sufficient confidence in other elements of the system to make changes to their own services</td>
<td>Cross boundary collaboration between commissioners and providers in the development and implementation of care closer to home services will increase shared knowledge, trust and confidence. The care closer to home (CCH) governance arrangements will underpin this work and the associated OD programme will help drive the shift away from ‘silo’ working to collaboration.</td>
</tr>
<tr>
<td>Informatics</td>
<td></td>
</tr>
<tr>
<td>Data quality is insufficient to support proposed contracting and reimbursement changes</td>
<td>The deployment of dedicated analytics staff to work with providers on data capture ensures the continual focus on ensuring quality.</td>
</tr>
<tr>
<td>Informatics unable to deliver IC priorities including shared care plan enablement</td>
<td>The IT/informatics requirements for the East London IC programme have been identified and shared with the East London informatics team. Next steps include workstream prioritising, including shared care plan enablement.</td>
</tr>
<tr>
<td>Contracting and reimbursement</td>
<td></td>
</tr>
<tr>
<td>GP federations are not mature enough to enable negotiation with other providers in each borough</td>
<td>Dedicated OD programmes are supporting GP provider network development. The PMO coordinates the sharing of local, national and international knowledge and experience, through East London IC leads and the national pioneer/vanguard support teams.</td>
</tr>
<tr>
<td>Care planning</td>
<td></td>
</tr>
<tr>
<td>Care planning has too many interpretations by clinicians and a common framework cannot be agreed</td>
<td>A task and finish group was established to develop an East London care plan template. Agreed principles and outline content were produced from a series of stakeholder workshops. The template is</td>
</tr>
</tbody>
</table>
being finalised with the aim of sign off at a final workshop in January 2016. In parallel, an East London project is being initiated by UCLP to formalise patient centred collaborative working, to ensure effective MDT working re care planning.

1.8 Next steps

We expect our proposed care model/changes will be developed and enhanced as a result of further testing and development of the strategy in the following key areas:

1. Engaging with staff and key stakeholders on an ongoing basis to inform development, and a further iteration to develop care models and associated systems and processes e.g. MDT/ collaborative working approach; There is a follow-up leaders’ meeting for Waltham Forest in January 2016 is planned; and an evaluation workshop is planned for February 2016 where we will seek to engage specifically with front line staff and clinicians.

2. Undertaking detailed workforce modelling, capturing all existing workforce information and planned developments, to ensure that the proposed care model is effectively supported by workforce changes, both immediate and planned.

3. Ongoing financial assessment of the activity modelling, costs and savings, including implementation costs and benefits for each initiative, ensuring alignment with each organisation's own income and expenditure plans, to validate a clear annual benefit.

4. Exploring reimbursement options more broadly so as to identify payment systems and incentive schemes which deliver the desired changes in provider behaviours.

5. Implementation planning to provide an overall phased and prioritised programme of change. Prioritisation and phasing will be completed based on those schemes that are expected to have the most impact on ensuring East London has high quality, safe and sustainable services and will incorporate an assessment of deliverability. This work will also take into account interdependencies with the CQC improvement plan at Barts Health and the different workstreams on each other, including our enabling workstreams (IT, estates, workforce and payment systems).

6. Developing impact assessments for the individual and collective proposals, including travel and equalities.

7. Strengthening the necessary leadership, governance, and system-wide capacity and capability.
2: Put in place a more integrated urgent care model

2.1 The case for change

The need to redesign urgent and emergency care services in England and the new models of care which propose to do this are set out in the Five Year Forward View (5YFV)\(^\text{15}\). The Urgent and Emergency Care Review proposes a fundamental shift in the way these services are provided, improving out of hospital care so that we deliver more care closer to home and reduce unnecessary hospital attendances and admissions. The 5YFV highlights that we need a system which is safe, sustainable and provides consistently high quality care. The vision of the review is that for those:

- people with **urgent care needs**, a highly responsive service should be delivered as close to home as possible, minimising disruption and inconvenience for patients and their families.
- people with **more serious or life threatening emergency care needs**, the health service should ensure that they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

In designing this strategy, the growing and ageing population and the impact that neighbouring borough plans will have on demand for services has been taken into account.

The rising demand from our population, combined with the planned reconfiguration of the emergency department at King George Hospital, means that if we do not change the way we configure our services, by 2020 there is likely to be an increase of 92,000 people per year visiting our local emergency departments.

One of the key objectives therefore in designing this strategy is to ensure that our emergency departments are used for emergencies only. We know from local health data that up to 21\% of those who currently attend emergency departments, but who are not admitted, require no significant treatment\(^\text{16}\), and could have received their treatment in another setting. Of this cohort, up to a third were children and young people. We also know from national evidence that people with a mental health need account directly for approximately 5\% of emergency department attendances and most people who frequently re-attend emergency departments do so because of an untreated mental health condition\(^\text{17}\). In order to ensure that our emergency departments are used for emergencies only we need to therefore offer real alternatives closer to home regardless of age and type of urgent need. For more information on how East London will be redesigning emergency care, please see the acute care hubs transformational scheme, detailed in part 3, section 6.

Work we have completed to date has shown that:

- people are not supported sufficiently to manage their own conditions\(^\text{18}\)

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\(^{15}\) [www.england.nhs.uk/2014/08/15/5yfv/](http://www.england.nhs.uk/2014/08/15/5yfv/)

\(^{16}\) SUS data 2014/15

\(^{17}\) Transforming urgent & emergency care services in England Urgent & Emergency Care Review Nov 2013

\(^{18}\) [Case for Change. Transforming Services Changing Lives](http://www.transformingservices.org.uk/downloads/caseforchange/TSCL%20case%20for%20change%20FINAL%20web.pdf)
• around 20% of GP workload is spent treating people with minor ailments which could be treated by visiting one of our 176 local ‘walk in’ pharmacies or through self-care
• primary care access is currently poor in East London and segments of our population are not finding it easy to access our 141 GP Practices in the traditional way. This means that some people choose to attend emergency departments when they are unable to get a GP appointment
• there is variation in service provision of our community rapid response services in terms of opening hours
• up to 52% of ambulances arriving at our emergency departments are transporting people who attend but are not admitted to hospital. Of these up to 12% required no significant treatment
• East London urgent care centres do not all meet the urgent care facilities specifications set out in NHS England, London Healthy Partnership. Currently there is variation in opening hours and available clinical expertise, as well as variable access to diagnostics, which is leading to increased referrals to our emergency departments
• our current payment system does not incentivise or support system working
• our current IT system is not fully interoperable which means that clinical records, ‘special notes’, care plans and summary care records (SCR) cannot be easily shared.

Responding to the above case for change is critical to ensuring that we can continue to offer a sustainable, high quality urgent care service to our growing populations.

2.2 Model of care

Our strategy for urgent care closer to home is to simplify the entry into the urgent care system so that people receive the right care, in the right place, first time. Our new urgent care system will recognise the needs of all our age groups – children and young people, adults and older people – and will be able to meet urgent care needs closer to home whether people are presenting with a physical or a mental health need.

Helping people to navigate the system easily ‘click first’: To help people have access to the right service, in the right place, first time we will promote and develop the use of an online directory of services known as My Directory of Services (MiDoS). This is simple and easy to use and describes where services are and how to access them.

The NHS 111 clinical triage service ‘phone first’ will be integrated with the urgent care system. The diagram below shows that the service will be able to direct people to self-care, pharmacies book people into the primary care hubs or, if the level of need necessitates,
within the urgent care centres. The primary care hubs will have a wide range of professionals such as GPs, pharmacists, dental, community health and social care services for people of all ages and for people with a physical and/or mental health need. Where level of need indicates people will be booked into the urgent care centres which will have a multi-professional workforce with access to diagnostics. People requiring ambulatory care services will also be able to be booked into these services directly from NHS 111. These changes will ensure that people are seen quickly and conveniently.

Use of NHS 111 as a single point of entry

*Registered patients will be encouraged to contact their own GP first

**Increase the confidence in people managing minor illnesses:** East London residents are already becoming more confident in managing minor illnesses on their own. To increase this confidence further, online resources will be continuously updated and improved. Digital applications (apps) that offer advice for minor illnesses will be provided and more self-care courses will be offered.

Pharmacies will also play an important role when residents want further support in managing their illnesses. MiDoS will locate local pharmacies and help raise the profile of the support pharmacies can provide. The integrated urgent care system will also be able to direct residents to pharmacies when it is appropriate to do so.

**Improve same-day access in primary care:** Up to a third of residents are not able to book an appointment at a time that is convenient to them. Many of these people will have urgent care needs and will, as an alternative, seek help from other services including emergency departments and hospital-based urgent care centres. Many people’s urgent care needs can be met more effectively by primary care. Through the work with primary care GPs will have

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28 Ambulatory care is a patient focused service where some conditions are able to be safely treated on the same day which previously have required an overnight stay in hospital

29 GP Patient survey results 2014/15
more time to be able to assess and treat people more relevant to their skill sets. Current evaluations are also underway on pilot schemes which are extending GP opening hours within primary care hubs after 18:30 weekdays and at weekends. If these are successful the extended GP hours will form part of local offers.

**Improve accessibility to community services:** Within primary care hubs there will be collaborative working with GPs, pharmacies, dental and community health and social care services, connected by IT and improved payment mechanisms to work together to provide an integrated urgent care response closer to home. Our current walk-in services will become part of the primary care hub offer with current activity being absorbed by improved access to GPs, pharmacies and self-care.

We will also look at how we can improve current services. This will include improving rapid response teams (adults and children) and mental health crisis teams so that they are able to respond to people’s needs over a 24 hour period. We will also work towards further investing in community ambulance technicians so that more care can be delivered, when appropriate to do so, at the scene in collaboration with our GP’s and community health teams.

The integrated urgent care system will work closely with community nursing staff caring for people with long term health conditions or receiving end of life care in their own homes, including care homes.

**Strengthen the urgent care offer at the front of our emergency departments with the right workforce and appropriate access to tests 24 hours a day:** If emergency departments are to successfully provide 95% of care within four hours, strengthened urgent care centres are needed at each site.

Within the urgent care centre the workforce skill-mix will be broadened to include multidisciplinary teams, including at least one registered practitioner and at least one healthcare practitioner. Arrangements will also be in place to have access to experienced doctors of at least staff grade 4 registrar level in both adult and paediatric emergency medicine and practitioners with mental health skills will also be available. The urgent care centres will also have access to a medical or non-medical prescriber and access to diagnostic test facilities including X-Ray and bloods so that they can cater for a much broader range of conditions.\(^30\)

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\(^{30}\) Urgent and emergency care facilities specification
2.3 Engagement to date

In developing this strategy we have been working extensively with our local stakeholders. We have also linked in closely with the work of NHS England and the London Healthy Partnership to ensure that local solutions are aligned with, and will impact positively on work taking place across the city.

Engagement sessions to date:

- Newham Urgent Care Working Group
- Tower Hamlets Urgent Care Working Group
- Waltham Forest Urgent Care Working Group
- TST Patient and Public Reference Group
- TST Urgent Care Steering Group
- Tower Hamlets Patient Focus Group
- Newham clinical and engagement patient session

2.4 Outcomes the change will achieve

The integrated urgent care system is intended to achieve the following outcomes:
<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 20/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting NHS constitution emergency department 95% four hour wait standard</td>
<td>Each emergency care department will consistently meet the 95% four Hour target</td>
</tr>
</tbody>
</table>
| Meeting urgent care centre assessment and treatment times | • All patients are to be seen and receive an initial clinical assessment by a registered healthcare practitioner within 15 minutes of the time of arrival at the urgent care service  
  • Within 90 minutes of the time of arrival at the urgent care service 95% of all patients are to have a clinical decision made that they will be treated in the urgent care service and discharged or arrangements made to transfer them to another service  
  • At least 95% of patients who present at an urgent care service to be seen, treated if appropriate and discharged in under three hours of the time of arrival at the urgent care service (where clinically appropriate). |
| Children and adolescents | Single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes. Psychiatric assessment to take place within four hours of call |
| Summary care records | 100% of patients have an episode of care summary communicated to the patient’s GP practice by 08:00 the next day. For children the episode of care is also to be communicated to their health visitor or school nurse, where known and appropriate, no later than 08:00 the second day |
| Proportion of people accessing urgent care system via NHS 111 versus walk in | • 70% of access to the community based urgent care system is via NHS 111 single point of entry by 2017/18  
  • 80% of access to the community based urgent care system is via NHS 111 single point of entry by 2018/19  
  • 90% of access to the community based urgent care system via NHS 111 single point of entry by 2019/20 |
| Increase in % of people using pharmacies | 50% increase in use of pharmacies for minor ailments |
| Increase in levels of people being treated closer to home | 10% decrease in ambulance conveyances to emergency departments of patients attending but not admitted |

Please note this list is not exhaustive
2.5 Investment costs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital costs inc.</td>
<td>£86k</td>
<td>£86k</td>
<td>£86k</td>
<td>£86k</td>
<td>£344k</td>
<td></td>
</tr>
<tr>
<td>capital revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Modelled as part of tariff</td>
</tr>
<tr>
<td>OD costs</td>
<td>£60k</td>
<td>£200k</td>
<td>£120k</td>
<td></td>
<td></td>
<td>£380k</td>
</tr>
</tbody>
</table>

Other investment costs

To manage the additional urgent care activity being delivered closer to home, more resource will be required in the new integrated NHS 111, pharmacy, primary care hubs, and the urgent care centres. These resource costs will be further identified as part of the full business case development.

2.6 Impact on activity and revenue

Impact on activity

The integrated urgent care system will mean that an increased level of care can be safely carried out away from the hospital setting. This will be achieved through NHS 111 having increased levels of clinicians on the calls, self-care tools accessed on line, increased uptake in pharmacy, improved same day access in primary care and strengthened service offers within primary care hubs and urgent care centres. It is envisaged that the integrated urgent care system will reduce emergency department activity by 26%. The following graphic shows the different care settings in which this 26% of activity will be delivered.
Please note it is also assumed that additional call activity will go to NHS 111 and this has been assumed as a 70% of current walk in activity

Impact on finances and sensitivity analysis

After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £2.5m to £5.8m over a five year period.

In addition the proposed payment model for the integrated urgent care system is currently being piloted by eight vanguard sites. These sites are reviewing a new three-part payment model which includes the following elements:

- % of resourcing at fixed costs
- % of resourcing at variable cost
- % outcome based costs and linked to improving quality

It is expected that if the three part payment model is successfully piloted the methodology will be rolled out to all urgent care systems. Waltham Forest, Newham and Tower Hamlets are closely linked into the work of the vanguards through the North East London Network which consists of Barking and Dagenham, Havering, Redbridge, Waltham Forest, Tower Hamlets, Newham and City and Hackney Clinical Commissioning Groups (CCGs). East London CCGs will be evaluating the impact of any new payment models on the urgent care system and will be adapting the financial framework accordingly.
Further financial validation including the impact on providers will be included as part of the next steps alongside considerations on procurement, financial phasing and payment innovation.

2.7 System commercial considerations and transitional support required

The integrated urgent care procurement group consists of the seven north east London CCGs (Barking and Dagenham, Havering, Redbridge, Waltham Forest, Tower Hamlets, Newham and City and Hackney). The group is planning to re-procure the new NHS 111 clinical triage to ‘go live’ by April 2017.

2.8 Delivery risks

The table below outlines the current main risks to delivery

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk likelihood</th>
<th>Risk impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Full IT interoperability solutions are not expected to be in place by the</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Work is underway at NHS England and local level to mitigate this risk</td>
</tr>
<tr>
<td>anticipated ‘go live’ date April 2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Lack of clinical engagement</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Clinicians have been involved through workshops and 1-1 meetings to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ensure that views have been captured</td>
</tr>
<tr>
<td>3 Lack of providers available to fulfil service specification criteria for the</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Work is underway to assess the market and numbers of providers who</td>
</tr>
<tr>
<td>new integrated urgent care system</td>
<td></td>
<td></td>
<td></td>
<td>will be able to fulfil the remit</td>
</tr>
</tbody>
</table>
2.9 Next steps

Data evidence

The further steps are taking place to add quality to the evidence base

- Carrying out validation checks on the database which has been used for modelling and taking corrective action in future modelling where needed
- Completing public health work to review the causal factors for emergency department attendances and standardise variations by each GP practice to further add confidence to the assumptions
- Completing the linkage work to identify the percentage of people who access the urgent care system through multiple points. This work will add confidence to the assumptions and will also be a good measure of improvement when the new integrated urgent care system is fully implemented
- Further financial phasing to include further shifts in activity to for example self-care and pharmacy

Procurement

North east London CCGs are working collaboratively to procure the new NHS 111 clinical triage system. Locally Waltham Forest, Newham and Tower Hamlets are also working on the implementation plans to integrate the rest of the urgent care system with the new NHS 111 and will be reviewing further procurement plans as part of this.

Procurement key milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement to proceed with preferred timeline including the NHS England assurance meetings</td>
<td>October 2015</td>
</tr>
<tr>
<td>Clinical visioning workshops will be held which will further specify what care is provided within the primary care hubs and how they will be connected through improved IT</td>
<td>October 2015</td>
</tr>
<tr>
<td>Arrangements to agree support to develop the service specifications</td>
<td>November 2015</td>
</tr>
<tr>
<td>Development of service specification and business case</td>
<td>November 2015 – January 2016</td>
</tr>
<tr>
<td>Engagement with stakeholders including public engagement</td>
<td>February 2016</td>
</tr>
<tr>
<td>Approvals of final specification and procurement process</td>
<td>March 2016</td>
</tr>
<tr>
<td>Procurement</td>
<td>March – August 2016</td>
</tr>
<tr>
<td>Award of contract</td>
<td>September 2016</td>
</tr>
<tr>
<td>Mobilisation period</td>
<td>October 2016 – March 2017</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Start of new NHS 111 service contract</td>
<td>1 April 2017</td>
</tr>
</tbody>
</table>
3: Improve end of life care

3.1 The case for change

“You matter because you are you, and you matter to the end of your life.”

Dame Cicely Saunders, Founder of St Christopher’s Hospice (1918 - 2005)

As highlighted in the Department of Health *End of Life Care Strategy*, one in three people admitted as emergencies to a hospital are palliative patients\(^{31}\). The strategy also made clear that 50-70% of patients with progressive illness expressed that they would prefer to die in their usual place of residence. Local data shows that only 22-29% people died in their usual place of residence in East London\(^{32}\).

This evidence, combined with a lack of a standardised local system for conducting end of life care planning means that there is significant opportunity to improve the experience of care towards the end of life for local residents, their families and carers. High quality end of life care should be available to everyone and should be provided in community settings where possible, through health and social care staff who are supported with adequate time, education and training\(^{33}\). The new national framework for action sets out six ‘ambitions’\(^{34}\), principles for how care for those nearing death should be delivered at local level:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help.

The diagram overleaf identifies some key areas of improvement and aspiration that health and care professionals from across East London identified as key areas of change\(^{35}\).

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\(^{31}\) *End of Life Care Strategy: Promoting High-quality Care for All Adults at the End of Life*. Department of Health, July 2008

\(^{32}\) SLAM Data, Barts Health 2011-2014, National EoL intelligence network 2014/15 Q2-3 and three year standardised rate 2011-2013


\(^{34}\) Ambitions for Palliative and End of Life Care: A national framework for local action 2015 – 2020, National Palliative and End of Life Care Partnership, September 2015

\(^{35}\) East London workshop on end of life care, March 2015
Key themes of the case for change

Across East London the key issues in relation of end of life care are:

- Inequity of access to high quality care, including 24/7 out of hours support services.
- Inconsistencies and inadequacies in the current care model.
- Fragmented systems for identifying, conducting and sharing care plans and referring palliative care patients to optimal settings of care.
- Poor or unmet patient and carer experience of care and expectations.
- Lack of a coordinated approach across organisational boundaries to deliver optimal care.
- Workforce challenges including training, recruitment, retention and potential demoralisation of staff providing care to palliative patients.

The engagement conducted to date suggests that the provision of end of life care for adults in East London does not fulfil NICE guidance. The Transforming Services Changing Lives (TSCL) Case for Change highlighted that people’s choices towards their preferred place of death are not always fulfilled. All three boroughs are below the national average for the proportion of patients dying at home (Newham 20%, Waltham Forest 18% and Tower Hamlets 22%) and above the national average of 49% for the proportion dying in hospital.

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36 End of Life Care for Adults, NICE quality standard (QS13), November 2011.
(Newham 64%, Waltham Forest 67%, and Tower Hamlets 59%)\textsuperscript{38}. Making sure a patient’s wishes are recorded and shared in order that fewer patients die in hospital (when it is against their wishes) is a key component of Barts Health’s \textit{Safe and Compassionate Care Improvement Plan}\textsuperscript{39}.

\textit{There is currently insufficient capacity to support people to die outside of hospital settings}

Enabling more people to die at home, or in a hospice surrounded by their loved ones is also a key enabler for relieving pressure on hospital beds. As the \textit{Strategy and Investment Case} illustrates, over the next ten years, without changing the way that care is delivered, the local health care system would need to build an additional 505 beds to meet the demand growth expected as a result of our growing population. This is unaffordable and would also mean that care would continue to be delivered in suboptimal care settings.

In order that the needs of a growing population can be met without building further hospital bed capacity, it is important therefore to invest in sufficient care in the community. Currently, despite many palliative care patients spending their last weeks and months in and out of hospital, bed utilisation in facilities suitable for providing hospice care is low. For example, St Joseph’s Hospice has a current bed utilisation of 69% and regularly has up to 19 beds free. If fully utilised, this has the potential of creating approximately 7,000 bed days for palliative hospice care, provided referrals from Barts Health can take place in a timely and supportive way. In addition, engagement conducted to date suggests that there may not be sufficient capacity in community services to support patients to die at home. Further investment in palliative care nursing teams, alongside good care planning is also likely to mean fewer people die in hospital settings.

Capacity also needs to increase in out of hours palliative care services. Across England, 20% of people who die experience three or more emergency admissions in the last year of their life\textsuperscript{40}. Providing consistent 24/7 support services in the community would reduce the need for these admissions. The engagement that has been conducted to date suggests that 24/7 palliative care services that can provide for people in their own homes are not in place locally, with care instead provided either by out of hours GP services, or through local accident and emergency departments, often resulting in emergency admissions.

\textit{Identifying palliative care patients and agreeing and sharing care plans is unsystematic across East London}

During the end of life care workshop in March 2015, a number of issues were identified within East London related to this area. To support people to die in line with their wishes, health and care professionals agreed that the health system needs to identify those approaching the end of their lives earlier, identify their care preferences more often, and agree care plans that are recorded and shared more systematically between providers.

The sharing of electronic care plans would greatly enhance care, not only between health providers but also across social care and the voluntary sector. For example, in Bedfordshire, an electronic register acted as a single point of care coordination that resulted in a 16% increase in life expectancy.

\begin{footnotesize}

\textsuperscript{39} \textit{Safe and Compassionate: Our Improvement Plan}. Barts Health NHS Trust, 2015.

\textsuperscript{40} Public Health England. \textit{What we know now: National End of Life Care Profiles}. 2014.
\end{footnotesize}
reduction of people dying in hospital\textsuperscript{41}. According to Age UK, few care plans have been completed in the boroughs of Tower Hamlets and Newham. It is anticipated that this is also true in Waltham Forest as engagement so far has suggested that there is not a systematic way creating care plans for palliative care patients.

\textbf{The training and development needs of our workforce}

Engagement conducted\textsuperscript{42} with health, social and voluntary sectors including families and carers has highlighted the urgent need for enhanced training for staff supporting patients towards the end of their lives. This engagement has highlighted that staff often struggle to start conversations early, which results in the care wishes not being recorded and care plans not being recorded. Staff have also highlighted their lack of understanding of agreed pathways and referral mechanisms for palliative care patients. Training and education which empowers staff to discuss options and deliver care with compassion will be crucial to improving end of life care in East London.

3.2 \textbf{The care pathway and model of care}

Discussions with key stakeholders including Barts Health, commissioning staff, Marie Curie and St Joseph’s Hospice have suggested that the pathway shown overleaf should be implemented consistently across East London.

\textsuperscript{41} Detailed in End-of-Life Care, The King’s Fund, 2014.
\textsuperscript{42} Dying Well event, Newham Community Health Services, November 2015 and End of Life Care Workshop, March 2015.
The key principles associated with the proposed new end of life care model for East London are described in the diagram below. This highlights the importance of defined processes that systematically identify palliative care patients, record their wishes and ensure care plans are shared between providers across the health and care system.
Implementing the new care model would mean organisations across East London would need to take the following action:

**Help people to die in accordance with their wishes.** Helping more people to die in accordance with their wishes through tailored and shared care planning is fundamental to improving end of life care in East London. Organisations need to:

- work with patients and their families to better understand their preferences towards the end of life
- provide enhanced training to care professionals to discuss end of life care preferences
- increase capacity in palliative care teams, out of hours services and the voluntary sector to better meet growing demand (see details below)
- establish clearer pathways for end of life care support between organisations, including referral mechanisms to hospices and palliative nursing teams from providers
- reduce unnecessary hospital admissions by ensuring high quality 24-hour care is available in the community.

**Ensure that patients who are towards the end of their life are identified so that care can be planned appropriately.** People need to be appropriately identified to ensure that they are able to express their wishes about their care during the last years of life. Although there are identification systems in place across the three boroughs, our engagement suggests relatively few care plans have been recorded to date. Therefore further analysis needs to be undertaken to assess how well these processes work. Whilst primary and community care should be the setting in which care planning takes place, in the short term, identification and care planning processes at Barts Health also need to be improved.

**Coordinate care for people towards the end of their life through a shared care plan.** Care needs and preferences should be available to patients and all appropriate care givers. Electronic shared care records (see part 3, section 10) will enable this coordination across organisational boundaries. Whilst EMIS does not presently have a care plan functionality in place, it is expected to release this function by September 2016, subject to further technical
assessment. This will be more beneficial than the systems some areas of London use, which are individual word templates held with the patient record but not structured, coded or sharable through the Health Information Exchange. Once the care plan functionality is in place, EMIS will have the ability to support the sharing of end of life care plans across systems connected to the Health Information Exchange i.e. Cerner, EMIS, RiO (for ELFT) and AzusCare (Newham Council). This is expected to provide a high degree of interoperability between providers.

**Develop community services enabling more people to die at a place of their choice at home or in a hospice, surrounded by their loved ones.** Work needs to take place across health, social and voluntary sectors to develop services which have sufficient capacity to enable people to die at home or at hospices. In order to prevent emergency hospital admissions, the services which are provided at home need to be available 24/7. In addition, referral pathways between hospital, hospice, district nursing and specialist palliative nursing teams need to be defined and properly mapped, including the provision available out of hours. Given occupancy rates are low at facilities that can provide hospice care (69% St Joseph’s Hospice, 50% East Ham Community Centre), commissioners, hospital and hospice staff should quickly act to improve pathways so that the pressure on acute beds can be reduced and patient experience of care towards the end of life can be improved. Organisations should also consider how greater partnership working with the voluntary sector can facilitate the changes we would like to see.

**Access to pharmaceutical services 24/7.** The provision of out of hours pharmacist support is vital. Engagement with palliative care nursing teams has suggested that access to palliative care medicine has been a constant concern, particularly out of hours when GPs are unavailable to prescribe. This creates a vicious circle which contributes to increasing attendances at emergency departments. As part of extending palliative nursing support to provide 24/7 care, access to pharmacists also need to be offered to aid patients and carers with pain control and symptom management.

**Develop the workforce to support patients in the last year of their lives.** There are a number of ways in which the workforce needs to develop to implement the new model of care:

- Health and social care organisations need to increase the knowledge and skills of staff throughout the pathway. All staff working in the care pathway should be trained to have supportive conversations with patients and their carers about their preferences and needs.
- The capacity of palliative care teams and expertise needs to be reviewed to ensure it meets increasing demand so that patients and their families receive prompt access to specialist advice and direct service.
- Recruitment and retention of the right staff and appropriate skill mix are crucial factors in the delivery of the new model. Organisations across East London should learn from examples of innovation in this area such as the way in which St Joseph’s Hospice is succession planning to support the potential future skills shortage in this area, through the training of Band 6 palliative care nurses for future, more senior roles.

In addition to the above care model changes, pathways need to ensure that support for families and carers does not end at the time of death. A King’s Fund report identified bereavement care as a key requirement within end of life care\(^\text{43}\). Appropriate bereavement

\(^{43}\) *Community Services – How they can transform care*. The Kings Fund. 2014.
services should be in place to support the ongoing health needs of those who have lost loved ones.\textsuperscript{44}

3.3 Engagement

The following stakeholders or stakeholder groups have been engaged or have helped to shape these proposals:

- Barts Health NHS Trust: directors, clinicians and senior managers
- Commissioners at Newham, Tower Hamlets and Waltham Forest CCGs
- St Joseph’s Hospice
- Marie Curie
- TST End of Life Care workshop with health and care professionals from across East London (March 2015)
- Newham Community Health Services ‘Dying Well Event’ (November 2015), involving carers and families

The above workshop and meetings with key stakeholders help to define the care model and gaps in the service.

3.4 Outcomes the change will achieve

The above model of care is intended to achieve the following outcomes.\textsuperscript{45}

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of practice registered patients on palliative care register</td>
<td>0.6 - 1%</td>
</tr>
<tr>
<td>Percentage of patients on palliative care register with an advance care plan</td>
<td>80%</td>
</tr>
<tr>
<td>Percentage of palliative patients records which are able to be shared across health providers, social and voluntary sectors (including out of hours providers)</td>
<td>80%</td>
</tr>
<tr>
<td>Percentage of deaths in the usual place of residence</td>
<td>80%</td>
</tr>
<tr>
<td>Percentage reduction of unplanned hospital admissions for palliative care patients</td>
<td>50%</td>
</tr>
</tbody>
</table>

\textsuperscript{44} End-of-Life Care. The King’s Fund, 2014.

\textsuperscript{45} Appropriate data feeds will need to be established as part of implementation planning.
3.5 Investment costs

Other investment cost assumptions for end of life care will be captured within the overall care closer to home costing (Strategy and Investment Case part 2, chapter 3.2) as they are not mutually exclusive from other schemes e.g. primary care, integrated care, urgent care. Informatics, training and education costs associated with implementing an EMIS palliative care module are included as part of the shared care records investment requirements (see part 3, section 10).

The organisational development costs estimate what is required for training and education; organisational development costs associated with encouraging organisations and staff to work together across organisational boundaries; and improvement workshops/events.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>£220k</td>
<td>£200k</td>
<td></td>
<td></td>
<td></td>
<td>£420k</td>
</tr>
<tr>
<td>development costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informatics</td>
<td>£20k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£20k</td>
</tr>
</tbody>
</table>

Workforce costs will need to be identified in greater detail based on community health demand and capacity analysis as part of the submission of a full business case (see 3.9 for more detail).

3.6 Impact on activity and revenue

Activity impact

The end of life care project aims to ensure that more care is provided closer to home or in hospice-based settings. This will improve patients' experience of care in the last weeks of life, help reduce pressure on hospital beds and help the health and care system to be more sustainable.

Whilst further analysis is required, it is anticipated that significant impact can be achieved through building a more proactive, coordinated and responsive system during the next five years. Around 60% of the c.2,000 patients who currently die following an emergency admission each year at Barts Health, could be cared for in line with their wishes in their usual place of residence or in hospice settings. This would mean better quality of care for patients and also help the system become more sustainable because it would greatly reduce pressure on hospital beds at sites that are currently operating at 97% capacity; aiding amongst other factors a reduction in cancelled operations.

The average length of stay for patients who die after being admitted via the emergency pathway is 15 days. A more proactive system for those with palliative care needs, including expedited referral pathways between providers, could reduce this to approximately 10 days and therefore move c.6,000 bed days a year to settings that are more appropriate for patients’ needs.

46 Further data validation is required on the percentage of deaths which are palliative in nature. An assumption of 60% has been made, with a further assumption (based on the lower estimate contained within national evidence) that around 50% would prefer to die in their usual place of residence or in hospice based settings.
Impact on finance and sensitivity analysis

Whilst further work needs to take place to validate the proportion of patients who could be better cared for in their usual place of residence or in hospice settings, the net benefit of improving end of life care is expected to be positive not only for the patients, but also for the health and social care system. In particular system efficiency would be gained from the reduction of length of stay at Barts Health, which would contribute to better use of beds to accommodate elective admissions and the 18 weeks pathway.

After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £1.6m to £3.4m over a five year period.

End of life care financial analysis assumptions.

The financial analysis illustrated above has been made in line with the following assumptions.

End of life care model

- Better coordination of care and enhanced community palliative care support will support more patients to be managed in their usual place of residence reducing admissions to hospital.
- Enhanced protocols and pathways between providers and hospice settings will result in a reduction in acute length of stay for palliative care admissions.

Activity and cost assumptions

- c. 2,000 patients died after an emergency admission to Barts Health during 2014/15 with an average length of stay of 15 days and bed day cost to commissioners of £272.
- Up to 600 of these deaths were palliative in nature with a minimum of 50% of patients preferring to die in their usual place of residence or in hospice based settings.
- Investment costs related to providing the activity in a different care setting over a five year period is estimated at 75% of current cost of acute provision i.e. £2.9m.

Data sources and modelling assumptions for length of stay reductions

- Deaths data obtained from Hospital Episode Statistics Admitted Patient Care data via Health and Social Care Information Centre from NEL CSU for Barts Health (all sites)
- Data has not been filtered on specialty, Healthcare Resource Group, diagnosis or procedure
- An average length of stay was used
- Advance care planning is assumed to achieve a 32% reduction in final admission length of stay
- Activity group: non-elective admissions only
- Age group: adults
- Cost per bed day: £272 (from SUS 2014/15 extraction)
- Assumptions on phasing of achievement of 32% of reduction in final admission length of stay are as follows:
  - 2016/17 – 0%
  - 2017/18 – 20%
  - 2018/19 – 60%
  - 2019/20 – 80%
  - 2020/21 onwards – 100%

Further validation of these assumptions will be made during December 2015.

**Admissions reduction**

Evaluation of the opportunity of this scheme to reduce unplanned secondary care admissions through patients being cared for in their usual place of residence or in an alternative preferred care setting will be conducted.

### 3.7 Delivery risks

The table below sets out the risks associated with the delivery of the new care model and any associated mitigations that the East London system will need to manage.

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk Likelihood</th>
<th>Risk Impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient workforce and skill mix to care for the palliative patients in the community</td>
<td>5</td>
<td>4</td>
<td>20</td>
<td>Conduct a full demand and capacity review within community health palliative care teams regarding any investment required (not factored in to date) Establish a robust recruitment and retention strategy Ensure that specific training is tailored to provide a skill mix workforce for the boroughs</td>
</tr>
<tr>
<td>Services are not able to identify palliative patients due to no system in place, coding issues, information is not recorded</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Provide enhanced training for health professionals to provide them with training to identify and discuss care needs with palliative care patients and training to ensure they are recorded appropriately on palliative care registers</td>
</tr>
<tr>
<td>Milestone</td>
<td>Description</td>
<td>Timescale</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>-------------</td>
<td>-----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cross organisational workshop to further define the care model</td>
<td>To define and agree end of life care model and actions for implementation</td>
<td>December 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validation of associated activity shift financial saving assumptions and investment required</td>
<td>The details in this document represent an initial modelling run only. Further validation is required based on greater clarity of the care model being obtained following a workshop in December 2015.</td>
<td>December 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce capacity and demand analysis</td>
<td>Mapping and analysis of community capacity and nursing provisions to support the end of life care model</td>
<td>December 15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stakeholder engagement</td>
<td>Engaging with key stakeholders across all sectors and providers including patient reference group and TST Patient and Public Reference Group on a regular basis to inform development</td>
<td>November 15 to March 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project working group</td>
<td>Establish a project working group with relevant key personnel and decision makers who are engaged and able to take on implementation planning and delivery</td>
<td>January 16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3.8 Next steps

The table below details the milestones that will form the next steps associated with this transformational scheme.
<table>
<thead>
<tr>
<th>Clinical validation of interdependencies</th>
<th>Work with clinical leads to rapidly test clinical interdependencies and future model</th>
<th>January 16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business case for potential community investment</td>
<td>Will require detailed capacity and demand analysis – to understand business case for community investment including bed contracts and the provision of community and palliative nursing capacity to support the new care model</td>
<td>By February 16</td>
</tr>
</tbody>
</table>
| Establish baseline data metrics to track improvement (across the boroughs) | Identify % of patients on the palliative registers  
Identity % of patients who have their preferred place of death recorded  
Identify % of deaths at Barts Health which are palliative in nature  
Identify % of palliative patients that have advance care plan in place | By April 16 |
| Implementation plan in place | Including plan to deliver the clinical change, IT, organisational development and workforce aspects of the new care model | By April 16 |
4: Improving access, capacity and coordination in primary care

4.1 The case for change

Since publishing the Transforming Services Changing Lives *Case for Change* our analysis has demonstrated that transforming primary care is fundamental to creating a high-quality, safe and sustainable health care system in East London. Primary care needs to change in order to meet the needs of the residents we serve, provide for our growing population and deliver more care closer to home and in the community.

Whilst there are examples of excellent practice in East London, often quality is variable, there is variation in patient outcomes and service configurations are complex and difficult to navigate. The north east London sector also ranks the highest in the amount of patient complaints in England, whilst challenges concerning the high level of population movement into and out of London’s boroughs can cause problems in providing continuity of care.

There is also an ageing GP population, working in a variety of ways, sometimes in old estate that is no longer fit for purpose. This is set against a backdrop of a growing population (and subsequent demand), increasing disease prevalence, particularly in mental health and long-term conditions, as well as an ongoing limited financial envelope.

The case for change for primary care services in East London is demonstrated through the following factors:

Growing demand due to population growth and changing demographics

- Significant population increases, up to 29% in some boroughs, will create additional demand on primary care services. Overall, our population is expected to rise by 270,000 by 2031; this will mean there will be 1.1 million additional primary care appointments over the next 10 years and 589k over the next five unless the care model is changed.

- The rising burden of chronic disease alongside an ageing population with increasingly complex care needs is increasing the demand for primary care services.

- Primary care needs to make better use of the extended-team (pharmacists, optometrists, nurses, care navigators) to cope with an ever-increasing demand for services. The average number of general practice appointments per person per year in England has risen from 3.6 to 5.5 between 1995 and 2008, with the reported current average being 6.1. If this rise in demand continues, because of workforce constraints, the quality of service available will be greatly affected. GPs in the future need to concentrate more of their time on those with long term conditions and complex needs and the wider-primary care team needs to support the treatment of those with minor ailments.

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48 CCG Outcome Indicators, Public Health analysis (2015)
50 The population of residents over the age of 65 is projected to rise by 60% (37,000) over the next 20 years (Case for Change: Transforming Services Changing Lives (2014)
51 The number of Londoners with complex conditions is expected to rise by a third in the next 10 years
Generally poor patient experience of access

- Around 40% of those asked in the GP National Patient Survey report that they cannot see a GP of their choice and over 30% report finding it difficult getting through on the phone. Our local analysis to date has confirmed what the London Call to Action has highlighted; there is significant variation in access to primary care services in East London. Whilst further analysis will be commissioned, our work so far suggests that supply is not meeting demand and core-hour sessions are not offering enough appointments to meet patient need. For example:
  - Local walk-in centre data shows that 70% of demand is in core hours
  - Analysis of opening times suggests that up to 50% of practices in some areas of East London shut at lunchtime
  - Patients’ experience of GP out of hours services is ranked in the bottom quintile of boroughs in England for all East London boroughs.

- GP practices across East London are not always able to offer patients a choice of access to a female GP. For example, in some areas in East London the male/female ratio of GPs is 70/30, whereas by 2017 the London average will be 50/50.

Significant workforce shortages and retention and recruitment challenges

- There are significant primary care workforce shortages and significant retention and recruitment challenges that need to be addressed. Newham and Waltham Forest already have below average numbers of GPs compared to the rest of London.

GP full time equivalents per 1000 CCG population (London CCGs, 2013)

Source: Health and Social Care Information Centre (2013)

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52 GP National Patient Survey (2014)
54 CCG Outcome Indicators, Public Health analysis (2015)
A high proportion of the GP workforce are at, or are approaching, retirement age; 38% of male GPs in Newham, 32% of male GPs in Waltham Forest and 12% of male GPs in Tower Hamlets are aged 60 and over, many of whom want to reduce the hours that they work.

Almost 30% of GPs in Newham want to reduce their workload over the next five years.

And 6% of Newham’s male GPs operate as single-handed practices meaning that they do not have direct colleagues to whom they can hand over their workload.

Nationally NHS England reports that by 2021 another 16,000 GPs will be needed.

**Male GP headcount by age (East London CCGs, 2013)**

Our analysis shows that without changing our model of care, we would require an additional 195 GPs in East London; something that is a major challenge given this is a national shortage area. We also know there are recruitment and retention challenges associated with primary care nursing staff.

There are also a number of skills shortages in primary care. For example, only 31% of the capital’s GPs believe they have received sufficient training to diagnose and manage dementia and only half of all GP associates in training have the opportunity to work in secondary care paediatric services to gain experience of identifying and managing sick children.

Some GPs and nurses, including those in training, have said they feel dissatisfied with the lack of career and development opportunities available to them. This has led some to consider not working in the area long term. In Newham only three GP Vocational Training Scheme trainees out of 15 obtained salaried positions last year. Focus groups have also highlighted that East London’s nurses are frustrated by the lack of career and pay progression.

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55 Excluding expected turnover including through retirement.
• Rising costs are making living locally impossible for many nursing and support staff members. This, alongside student debt, means that working in primary care in East London is in danger of being an unaffordable career choice. Few key worker incentives such as affordable housing opportunities are offered.

The combined impact of GP shortages, retirement, reduced hours and skills shortages means that we are not able to deliver the high-quality primary care service that our patients need without significant changes to the workforce profile, ways of working and the ways in which employees are supported throughout their careers.

Many of our challenges can only be overcome by primary care working at greater scale in more multidisciplinary teams. Staff will increasingly need to work across organisational boundaries to provide care for patients closer to home. Significant changes to practice will be required to enable this, with considerable organisational development support needing to be made available to local providers.

Federations or the new provider networks can beneficially assist primary care to work at greater scale, however they are currently operating at different levels of maturity, meaning that the full benefits they could offer have not yet been realised. Much further development needs to take place during the coming years, again enabled by organisational development investment.

Variation in outcomes and patient experience of services

• Health inequalities in East London are high. As outlined below, on many public health indicators the local population experience outcomes which fall in the bottom quintile, with some even falling within the bottom 1% nationally. Whilst some of these outcomes can be explained by population and demographic factors, system indicators relating to the extent to which patients with long term conditions feel supported to manage long term conditions are in the bottom 6% of all CCG areas in England.
### CCG Outcome Indicators ranked in the worst quintile in England (2015)\(^5\)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority</th>
<th>WEL CCGs</th>
<th>Newham CCG</th>
<th>Tower Hamlets CCG</th>
<th>Waltham Forest CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>1</td>
<td>One-year survival from all cancers (in bottom 6% nationally)</td>
<td>One-year survival from all cancers (2%)</td>
<td>Myocardial infarction, stroke and stage 5 kidney disease in people with diabetes (5%)</td>
<td>One-year survival from all cancers (4%)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>One-year survival from breast, lung and colorectal cancers (7%)</td>
<td>Potential years of life lost (PYLL) from causes considered amenable to healthcare – Female (2%)</td>
<td>Under 75 mortality rates from cardiovascular disease - Male (7%)</td>
<td>One-year survival from breast, lung and colorectal cancers (5%)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Under 75 mortality rates from cardiovascular disease –Female (21%)</td>
<td>Under 75 mortality rates from cardiovascular disease –Female (3%)</td>
<td>Under 75 mortality rates from respiratory disease –Male (7%)</td>
<td>Potential years of life lost (PYLL) from causes considered amenable to healthcare –Male (35%)</td>
</tr>
<tr>
<td>Enhancing quality of life for people with LTC</td>
<td>1</td>
<td>Proportion of people who are feeling supported to manage their condition (6%)</td>
<td>Proportion of people who are feeling supported to manage their condition (1%)</td>
<td>Health-related quality of life for carers, aged 18 and above (2%)</td>
<td>People with diabetes diagnosed less than a year referred to structured education (2%)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Health-related quality of life for carers, aged 18 and above (8%)</td>
<td>Health-related quality of life for people with a long-term mental health condition (1%)</td>
<td>Health-related quality of life for people with long-term conditions (12%)</td>
<td>Proportion of people who are feeling supported to manage their condition (3%)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Health-related quality of life for people with a long-term mental health condition (16%)</td>
<td>Health-related quality of life for carers, aged 18 and above (7%)</td>
<td>Proportion of people who are feeling supported to manage their condition (15%)</td>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s - Male (8%)</td>
</tr>
<tr>
<td>Helping people to recover from episodes of ill health or following injury</td>
<td>1</td>
<td>Patient reported outcomes measures (PROMS) for elective procedures - Knee replacements (8%)</td>
<td>Patient reported outcomes measures (PROMS) for elective procedures - Knee replacements (7%)</td>
<td>Patient reported outcomes measures (PROMS) for elective procedures - Knee replacements (5%)</td>
<td>Patient reported outcomes measures (PROMS) for elective procedures - Knee replacements (11%)</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Patient reported outcomes measures (PROMS) for elective procedures - Hip replacements (20%)</td>
<td>Hip fracture: multifactorial falls risk assessment (11%)</td>
<td>Proportion of adults in contact with secondary mental health services in employment (22%)</td>
<td>Emergency readmissions within 30 days of discharge from hospital (12%)</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Proportion of adults in contact with secondary mental health services in employment (22%)</td>
<td>Proportion of adults in contact with secondary mental health services in employment (12%)</td>
<td>Hip fracture: proportion of patients recovering to their previous levels of mobility/walking ability at 120 days (26%)</td>
<td>Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission (20%)</td>
</tr>
<tr>
<td>Ensuring a positive experience of care</td>
<td>1</td>
<td>Patient experience of GP out of hours services (14%)</td>
<td>Patient experience of hospital care (4%)</td>
<td>Patient experience of GP out of hours services (17%)</td>
<td>Patient experience of GP out of hours services (6%)</td>
</tr>
</tbody>
</table>

\(^5\) Each CCG, and east London’s position relative to a national ranking is shown in brackets. CCG indicators form part of the CCG Outcomes Indicator Set (CCG OIS), an integral part of NHS England’s approach to quality
Financial, estates and IT challenges

- The financial pressures associated with providing primary care services for a growing population are stark. Newham and Tower Hamlets are experiencing some of the highest rates of population growth in the country. With population growth already being observed and uplifts in primary care funding not increasing in real time, many of our services will become unsustainable. The local health and social care system needs to work with funding bodies to understand whether transformational investment can be provided ahead of further population growth so that the required infrastructure, including any capital investment requirements, can be put in place.

- East London has a high number of single handed practices\(^57\), some of which are not run from fit-for-purpose premises. Whilst estates improvements to these practices could be made, investment would be significant and may not be beneficial to implementing a primary care model in which multidisciplinary working is the norm. For example, surveys\(^58\) have highlighted that Waltham Forest’s primary care backlog maintenance costs over the next five years are likely to be £9 million.

- Primary care in East London has been relatively slow to embrace digital technology solutions that could support patients to self-care and seek advice in more convenient and cost effective ways.

4.2 Transforming primary care

The aim of this workstream is to transform, modernise and redesign primary care in East London by focusing on three areas of change:

1. **Improving access**: to primary care including general practice, pharmacies, dentists and optometrists

2. **Establishing proactive care**: empowering and supporting patients to take control of their health and wellbeing through self-care and peer support to manage long-term conditions

3. **Coordinating care better**: ensuring it is managed, organised and integrated around an individual’s care needs.

In order to achieve these priorities, four key enablers have been identified to support the change. These are workforce, estates, IT, and commissioning/contracting levers.

Implementing our vision would result in primary care offering a high quality and consistent service that meets the population’s needs. Primary care will be working at scale through multidisciplinary teams working together across organisational boundaries, in fit-for-purpose premises using modern technology.

In addition:

- Patients would be supported to take ownership of their own health and therefore have a greater say in their own care.

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\(^{57}\) NHS England contractual data (2015)

\(^{58}\) Waltham Forest CCG (2015) Six Facet Survey outcome for all primary care premises
• Commissioning decisions would be made with populations in mind in accordance with this strategy. Services would be commissioned at a practice or federation level, ensuring that primary care can operate at scale.

• New roles such as physician associates and pharmacists working in primary care practices would be established so that GPs can concentrate on more complex care.

• The use of wider primary care services e.g. pharmacists and opticians will be optimised. Some local GPs have reported that up to 40% of their workload is not a good use of their time and skills.

Our proposed care model in relation to each of the three areas

Improving access

Access will be improved through a variety of means including the development of multidisciplinary primary care teams; innovation in the way appointments are conducted; self-care support; and capacity and demand audits.

In the future, care will be provided by primary care teams with a greater variety of health and social care skills. For example, pharmacists working in primary care will be able to advise and treat common ailments allowing GPs to concentrate on more complex work.

Innovative ways of conducting appointments will be expanded in each borough to allow patients to access health care advice by email, Skype and text services. Up to 10% of patients currently accessing primary care services could self-care through supportive online advice and tools.

We will understand and commission for population needs, make it easier to register with a GP, facilitate registration for unregistered patients and provide same day access for unplanned care needs, all of which will be measured routinely by commissioners. Commissioners will then be able to make necessary and timely interventions where capacity does not meet local demand. Extended hours care, the provision of same day access and clinical triage models will be commissioned in line with our urgent care strategy, detailed in part 3, section 2.

• Health and wellbeing inductions will be offered to all new patients. As well as being offered health promotion advice, patients will receive information on how to access care appropriately and how to make use of available self-care tools.

• Minor ailments services in community pharmacies will be redesigned to encourage patients to seek advice and treatment for minor ailments in these settings.

Establishing proactive care

The single biggest change we can make to improve the sustainability of our health and social care system is to support people to take an active role in managing their own health and staying well.

More consistent and outcome focused care needs to be offered to the ever increasing number of people with chronic conditions. The identification and diagnosis of respiratory disease and diabetes needs to be increased and those on long term conditions registers need to receive proactive care in a more structured way to help them feel supported by the NHS to self-care and stay well. We also will need to strengthen our focus on making
preventative care a routine part of primary care provision and primary care will need to work collaboratively across boundaries with local authorities, community health services and voluntary sector partners to map services, promote healthier living, and co-design health promotion campaigns that enable improvements in residents’ health.

In the future, patients will have access to tools and information to make healthy lifestyle choices and self-care information and education will be published on GP websites. This will include symptom checkers and online triage systems.

Patients will be able to visit their local pharmacy to obtain advice and be treated for minor ailments. Our plans to create shared care records (see part 3, section 10) will allow providers outside of general practice to view the care needs of patients with long term conditions. We will pilot community pharmacy providers being able to input information directly to our primary care electronic record, EMIS.

Our work to establish proactive care models will again be supported through health and well-being inductions with new patients. Social prescribing also offers an innovative way for GPs to prescribe alternative community-based support that compliments traditional medicine. For instance people can be referred to local activity groups if it would better meet their health and wellbeing needs.

Coordinating care

Approximately 50% of appointments are for people with long-term conditions. By proactively planning care around an individual’s needs, we could significantly reduce the number of unnecessary NHS visits a person has to make. This will enabled by:

- a significant investment in technology to ensure there are innovative ways to access advice (phone, Skype, text)
- making sure 20% of total appointments are longer, to suit the needs of patients with complex long term conditions. This is especially important for first care planning sessions so that patients are properly supported to self-manage their illness
- the establishment of multidisciplinary teams which can proactively plan care around the needs of individuals
- investment in organisational development and training to support the workforce in establishing integrated working across the health and social care system.

How the new care model will be supported through the key enablers

Workforce

The new care model cannot be implemented without a fundamental transformation of our workforce, including organisational development support to help providers and teams work better together across organisational boundaries.

Given the workforce challenges associated with skills gaps, recruitment and retention, we will need to find other, sustainable, ways of delivering high quality primary care in East London over the medium and long term future. This can be achieved by using a more varied and multidisciplinary primary care team.
i) Diversification of the future workforce

In the future it is envisaged that GPs will work alongside physician associates (PAs), nurse practitioners, practice nurses, healthcare assistants, pharmacists and a greater variety of support staff in practices.

Focus groups have suggested that around 30% of the GP workload can be transferred to other health and social care professionals so that GPs can concentrate on those with more complex care needs. National analysis also suggests that around 11% of a GP’s time is taken up by administrative tasks. Our initial aim is to remove 5% of total activity through the widespread establishment of medical assistant administrator roles who will be responsible for call and recall, processing referrals, dealing with consultation outputs that require a level of knowledge of services available across the East London health and social care system.

As highlighted in the graph below, in ten years’ time, it is estimated that in terms of new roles we will require a total of 106 pharmacists and 38 physician associates. In terms of more traditional roles, we will need 238 nurses up from c 175 currently; c.400 GPs down from over 600 currently and 130 administrators (a similar number to the current workforce) to deliver our new model of care to the growing East London population.

ii) New ways of working and organisational development

In the future, hospital and primary care staff will need to work and increase collaboration to meet patients’ care needs as care moves closer to home. Professionals will routinely work across organisational boundaries. Significant investment in organisational development, additional training and the empowerment of the primary and community workforce will be required to enable people to work in this way.

iii) Recruitment and retention

A cross-system recruitment and retention strategy will also be established across the three boroughs, which considers the investment in our workforce that is required to make
East London a health and social care system of choice for our highly skilled workforce. There needs to be much greater focus on supporting and developing the careers of our health care staff. Federations will be encouraged to support employment, education, and training, as well ensuring leadership roles (clinical and non-clinical) are fostered.

Strategies to improve retention of primary care staff for East London CCGs include:

1. Provision of key worker housing
2. Financial incentives such as support with student loans
3. Flexible working options
4. Offering career development paths
5. Improve job satisfaction through regular communication

Retention of existing skills will need to be supported by the ability to offer flexible options for those considering retirement, such as different working patterns to facilitate stepped retirement. These will need to be managed within the new vision for service provision, and with the aim of promoting and ensuring that the new model of GP facilities and infrastructure, to provide services at scale, is not compromised.

**Estates**

Whilst this strategy focuses on multidisciplinary team and collaborative working, in Newham 20% of practices are run by single GPs, meaning that it is more difficult to accommodate the new ways of working.

Number of GPs (headcount) per practice by CCG, 2013

![Number of GPs (headcount) per practice by CCG, 2013](source: Health and Social Care Information Centre (2013))

Sustainable, larger GP practices that support multidisciplinary working through hub and spoke models and networks collaborations will be crucial in realising our vision. In order for this to happen, investments in facilities such as Centre Manor Park in Newham will be prioritised as part of the borough estates strategies we are completing by March 2016.
In the future, commissioners will invest in buildings which drive economies of scale and are best able to provide the new model of care. This may include the co-location of federated smaller practices in fit-for-purpose buildings. In order to provide capital investment, underutilised assets that are not suitable for the new model of care, or located in areas not experiencing population growth may need to be sold. Wasted space will be proactively reduced and plans will be put in place to maximise the utilisation of the existing estate that could, through service change, meet future requirements sustainably.

National evidence suggests that smaller GP practices struggle to sustainably provide all of the services future models of care will expect. The traditional partnership model, which currently serves an average of 6650 patients per practice, is widely acknowledged to be too small to respond to the financial and demographic challenges facing the NHS. The London Health Commission’s report *Better Health for London* also calls for professional isolation in general practice to be addressed.

This national evidence is in line with our local recommendations for a new model of primary care which is financially sustainable and allows primary care to operate at greater scale, through multidisciplinary working. Given our workforce and estates challenges, we believe this can only be delivered through primary care practices with list sizes over 10,000, through smaller practices working together at scale in integrated provider networks, or through collocating facilities at primary care hubs. General practice will need to adapt in line with this new model of care.

Whilst change is likely to mean that some patients need to travel slightly further for primary care, many more consultations will be provided by telephone or Skype and there will be less requirement for people to travel to a hospital, meaning that a significant proportion of care is provided closer to home. The borough estates plans that will be produced for March 2016 will make specific recommendations on how this element of the strategy is taken forward.

**IT and technology**

The new model of primary care means creating new and convenient ways in which patient consultations take place, for example by increasing the use of Skype. Increasing connectivity with systems within and across primary and secondary care will also allow faster and more convenient access to patients’ notes and results. This will allow timely diagnosis, and reduce unnecessary testing and appointments. These changes are described in further detail in the appendices on shared care records and diagnostics and will mean that by 2021, staff and organisations will need to use technology in a very different way. Providing sufficient user training and ensuring IT interfaces are user-friendly will be fundamental to success.

Proactive care needs to be encouraged and patients should be able to access their medical records online through an app or via the GP website, which will also be able to offer interactive tools such as symptom checkers. This will allow patients to manage their conditions and health records and to maintain healthier lifestyles.

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The following additional investments in IT and technology need to be made in order to implement the new care model and have been accounted for within the financial analysis in part 3, section 4.5:

- The establishment of a quality dashboard across the three boroughs with jointly agreed outcomes, including on patient access levels
- The piloting of easier methods to populate EMIS (e.g. for flu jabs, minor ailments, smoking advice).

**Commissioning and contracting levers**

In the future, CCGs will commission care from providers which operate at scale. CCGs will need to develop new contracting models which focus more greatly on improving health outcomes for local residents to support this.

Geographically close groups of practices working together in networks and federations will continue to be part of the commissioning strategy, with the further development of these arrangements being fundamental to reducing variation through peer support; collaboration; sharing of resource; increasing access; and reducing health inequalities. Increasingly, commissioners will invest money across geographical areas rather than in individual practices. This will enable services to be delivered at greater scale and efficiency. For example, call and recall functions for screening and immunisation vaccinations may all be able to be offered more effectively with greater cost benefit through primary care hub arrangements.

The shift to these new care models will be challenging and require **significant adjustment and behavioural change from providers, commissioners and patients alike**. To support this change to take place the scoping of new contract forms will be a key focus of implementation planning, as will the role of payment innovation and capitated budgets.

The overleaf below illustrates how primary care will be truly coordinated around the patient.
Other significant change initiatives not costed in this strategy

Significant other schemes related to this area of care that may in the future need to be impact assessed and costed:

- strategic development of new contract and payment innovations work
- a primary care centre as a potential option for the Whipps Cross redevelopment
- medicines optimisation initiatives.

4.3 Engagement to date

Over the last six months, we have engaged with the following organisational, clinical, stakeholder and patient forums. We have listened and incorporated feedback within this strategy.

The following stakeholders have been engaged

- CCG Board Meetings
- Primary Care Commissioning Committee at each CCG
- Primary Care Advisory Committee for WEL
- Primary Care Board for WEL
- Primary Care Development Committee at each CCG
- Locality meetings in each borough
- Primary care transformation workshops (across WEL and CCG specific)
- Primary care clinical leads, CCC chairs, Commissioning leads, workforce leads
- Focus groups with practice nurses, vocational training scheme GPs, GPs and practice manager
- Expert advice from UCL and Kings, CPENS
- Federation dialogues
- NHS England - primary care contracting and finance teams
- Local authority
- Barts Health public health team
- TST Urgent Care Programme
- TST Integrated Care Programme
- Primary care strategic estates groups,
- Community Health Partnerships
- WEL Pharmacy leads (acute and primary care)

4.4 Outcomes the change will achieve

The above model of care is intended to achieve the following outcomes:

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access in line with the London framework standards e.g.</td>
<td>All indicators to have 100% population coverage(^{61})</td>
</tr>
<tr>
<td>- Getting through on the phone</td>
<td></td>
</tr>
<tr>
<td>- Being able to see a GP</td>
<td></td>
</tr>
<tr>
<td>- Experience of OOH services</td>
<td></td>
</tr>
<tr>
<td>- Choice of healthcare professional</td>
<td></td>
</tr>
<tr>
<td>- Getting through on the phone</td>
<td></td>
</tr>
<tr>
<td>- Registering with a GP</td>
<td></td>
</tr>
<tr>
<td>Choice of sex of GP when making an appointment</td>
<td>Improvement trajectory to be set as part of implementation planning</td>
</tr>
</tbody>
</table>

\(^{61}\) Improvement trajectories to be set as part of implementation planning
<table>
<thead>
<tr>
<th><strong>Level of patient complaints</strong></th>
<th>Reduce level of patient complaints by 50% by 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All practices to be supported by strong network arrangements/working at scale</strong></td>
<td>100% of practices to have access to working in MDTs</td>
</tr>
<tr>
<td><strong>Improvement in retention levels</strong></td>
<td>75% of trainee GPs being retained</td>
</tr>
<tr>
<td><strong>Workforce recruitment levels</strong></td>
<td>On track to meet the plan (to follow as part of implementation stage) e.g. 25 extra physician associates in primary care by 2021, 58 extra pharmacists working in primary care by 2021</td>
</tr>
<tr>
<td><strong>Better use of skill mix</strong></td>
<td>To be detailed later 62</td>
</tr>
<tr>
<td><strong>Reduction of inappropriate use of Urgent Care and Emergency Care</strong></td>
<td>Reduction in the number of registered patients accessing Urgent and Emergency Care services Increase in the number of patients being signposted to GP registration</td>
</tr>
<tr>
<td><strong>Reduction in referrals / per 1,000 made from General Practice</strong></td>
<td>Increase use of specialist advice and alternative support being made within Primary Care</td>
</tr>
<tr>
<td><strong>Experience of care</strong></td>
<td>To be detailed during implementation planning 63</td>
</tr>
</tbody>
</table>
| • Safe high quality co-ordinated care  
• Available information and links to community resources  
• Transition between care  
• Environment – estates | |
| **Workforce satisfaction** | To be detailed during implementation planning 64 |
| • Learning and development  
• Health and well being | |

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62 Improvement trajectories to be set as part of implementation planning  
63 Improvement trajectories to be set as part of implementation planning  
64 Improvement trajectories to be set as part of implementation planning
4.5 Investment costs

In order to implement the model of care the following investments are required. This includes workforce investment, project implementation costs, organisational development costs and investments in IT. Expected capital costs will be further updated during 2016, as borough based estates strategies near completion.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital costs (estates/ IT infrastructure/equipment) including capital charges</td>
<td>£1.5m</td>
<td>£1.5m</td>
<td>£1.5m</td>
<td>£1.5m</td>
<td>£1.5m</td>
<td>£7.5m</td>
</tr>
<tr>
<td>Workforce (recruitment process costs and total project management costs)</td>
<td>£1.23m</td>
<td>£1.23m</td>
<td>£1.23m</td>
<td>£1.23m</td>
<td>£1.23m</td>
<td>£6.16m</td>
</tr>
<tr>
<td>Organisational development costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational development costs</td>
<td>£3.47m</td>
<td>£3.15m</td>
<td>£3.15m</td>
<td>£3.15m</td>
<td>£3.15m</td>
<td>£16.07m</td>
</tr>
<tr>
<td>Informatics</td>
<td>£1.04m</td>
<td>£0.74m</td>
<td>£0.74m</td>
<td>£0.49m</td>
<td>£0.49m</td>
<td>£3.5m</td>
</tr>
<tr>
<td>Other service investment costs</td>
<td>£300k</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£300k</td>
</tr>
<tr>
<td>Systems redesign support, e.g. smart interactive telephones systems, translation services procurement with additional written resources for registering and access pathway.</td>
<td>£2m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£2m</td>
</tr>
</tbody>
</table>

Investment in organisational development support

Given that the changes described within this strategy are so significant and require staff and organisations to work in a fundamentally different way, £16 million of investment over five years is required for organisational development work. This is a critical component of the transformation programme which supports the delivery of the wider care closer to home workstream, with the focus areas for investment being:

1. *Strengthening multidisciplinary team-working in primary care as part of the care closer to home strategy:* to support staff to work together across organisational boundaries to deliver the new care model (includes a diagnostic of need): £800k a year for five years.

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65 Expected capital charged: to be finalised following the final publication of borough estates plans in March 2016
66 This relates to improvement work within the Care Closer to Home strategy as a whole but for the purposes of financial assessment has been included within the primary care workstream
67 For minor ailments scheme – anticipated cost of redesign to be further evaluated within implementation stage
2. **Supporting, introducing and embedding new primary care roles as part of the care closer to home strategy:** supporting pharmacists, healthcare assistants, optometrists, practice managers, care navigators etc. to successfully deliver the new care model will be crucial to its success: £1.49m a year for five years.

3. **Leadership programme:** identifying future leaders at all levels of the MDT and supporting them through action learning sets, coaching programmes etc.: £70k a year for five years.

4. **Patient development and empowerment programme:** programme to support the patient voice to be a fundamental part of commissioning new primary care services as part of the care closer to home strategy, including involvements in the design of self-care models and the provision of Skype/telephone clinics: £820k a year for five years.

### Workforce requirements

The table below identifies the additional workforce requirements over the next five years which will enable the new model of care. Given that (due to recruitment challenges and retirements) GPs are likely to make up less of the future workforce\(^6\), their higher relative cost means that total workforce cost for primary care is likely to be £32m less expensive by 2021.

<table>
<thead>
<tr>
<th>Workforce requirements</th>
<th>Band (if applicable)</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician associates</td>
<td></td>
<td>25</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>7/6</td>
<td>58</td>
</tr>
<tr>
<td>Admin</td>
<td>5</td>
<td>-2</td>
</tr>
<tr>
<td>Community staff</td>
<td>5</td>
<td>46</td>
</tr>
<tr>
<td>Nurses</td>
<td>7</td>
<td>49</td>
</tr>
<tr>
<td>GPs</td>
<td></td>
<td>-136</td>
</tr>
</tbody>
</table>

### 4.6 Impact on activity and finance

**Impact on activity**

The charts below show the extent to which future expected demand is met (depending on whether the proposed model of care is taken forward). Without change there are expected to be an additional 589k appointments required in primary care by 2020/21:

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\(^6\) Due to the age profile, retirement and recruitment challenges given the national shortage
The new model of care is expected to create additional capacity to ensure primary care can cope with future expected growth. The orange bars highlight the proposed activity shift from general practice to pharmacies, self-care and other primary care providers such as opticians and dentists which acts to reduce demand.

The proposed 24% shift out of general practice is made up of 14% of activity which will be directed to wider primary care providers (pharmacists, optometrists, counselling and psychology services) and 10% which will be accounted for by patients being better supported to self-care. This shift is necessary because the primary care system needs to
meet growing demand and anticipated activity shifts from urgent care and hospital based services.

The 24% activity reduction target has been chosen because:

- National evidence, guidance and our engagement so far suggests that around 10% of activity can be shifted to self-care by equipping patients with the right advice, health care tools and signposting.

- Around 20% of a GP’s workload concerns advice and treatment for common ailments which could be seen by another provider e.g. pharmacists or via self-care. A proportion of appointments are also non-health related queries. It is estimated that primary care signposting to other services would mean an additional 4% shift.

- Approximately 20% of current general practice appointments will be longer so that GPs can fully meet the needs of those with complex long term conditions within the high risk integrated care cohort.

- There is a need for a 0.5% total increase in activity (96k episodes by 2021) as a result of a necessary shift from hospital or urgent care settings to primary care to aid patients being treated in the most appropriate care setting for their needs.

Impact on financial sustainability including sensitivity analysis

By 2021, it is expected that there will be a more financially sustainable model of primary care in place in East London. After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £30.7m to £34.5m over a five year period.

This calculation is driven by the changing profile of the workforce and a more efficient and effective model of primary care being in operation that is working at greater scale. The calculation, for example incorporates the anticipated benefits of physician associates working in primary care. In addition, many of the changes made by primary care in other parts of the country have not been made throughout East London, meaning there is significant scope for improvement. Making the substantial investments that are detailed in part 3, section 4.5, to help transform and redesign services to work at scale will however be crucial to success.

Whilst the financial savings figures include assumptions regarding the future funding growth that is expected, no provision has been made for growth in long term conditions which needs to be better understood as part of next stage financial validation and implementation planning for both pathway redesign and primary care workstreams.

Minor ailments treatment will be more cost-effective under the new care model

The current cost to the system for delivering minor ailments via general practice is estimated to be £76.4 million. If in the future this is delivered by the other primary care providers (pharmacists, optometrists, dentists), the cost to the system is estimated as being £27m. This results in approximately £50 million cost avoidance which can then be reinvested.

Cost of the future primary care workforce

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71 Improving Care through Community Pharmacy: a call to action. NHS England (2013)

72 Based on assumptions within ‘Pharmacists could save the NHS 1.1bn by treating common ailments’ 19/10/2014, available at www.rpharms.com
Using these figures and a range of other assumptions, the cost of the future primary care workforce has been modelled. The workforce needs to diversify:

- In ten years, it is estimated that East London will require a total of 106 pharmacists, 38 physician associates, 238 nurses, c.400 GPs and 130 administrators in practices to deliver the new model of care to the growing population.

- The overall cost of the primary care workforce is currently around £85 million a year. By implementing the interventions outlined in this strategy we expect this cost to drop to around £78 million whilst delivering roughly an extra 1 million appointments a year by ten years’ time.

- As the charts below illustrate, the savings are driven by less expensive roles being introduced under the guidance of GPs. The average salary per full time equivalent (FTE) decreases over ten years from £91k to £75k.

These forecasts show that it is possible to balance the cost of increased numbers of staff needed to deal with the increase in activity with less expensive roles resulting in a reduced cost per full time member of staff overall and a reducing overall cost of a GP-led, but MDT-provided primary care service.
The activity and financial analysis has been made in line with the following assumptions:

**Assumptions details:**

- The activity baseline used has been based on the assumption that general practice is currently operating at 100% efficiency (e.g. offering 72 apts. per 1000 registered population/per week)
- The proposed shift from hospital and urgent care settings needs to be completed in a phased manner over the next ten years in line with the rate at which general practice is able to transfer activity to self-care and other primary care providers
- The current contract will not provide a vehicle by which the new models of care proposed in this document can be delivered.
- The following factors affecting future demand have been modelled; TST activity shift from other care settings; activity related to future population growth of 270,000 by 2031
- The following factors have not been accounted for within modelling; the rising levels of average attendances that with primary care services are experiencing from patients; the expected 10% rise in LTC during the next ten years; rising life expectancy meaning more people are likely to require managed care for longer; more complex care being shifted into general practice from hospital.
- The cost of treating minor ailment in different settings has been assumed to be A&E £147.09, GP £82.30, pharmacy £29.30 (Royal Pharmaceutical Society).

### 4.7 System commercial considerations and transitional support required

Whilst there will be a reduction in minor ailments activity, the increased demand associated with a growing population means that income generated by general practice does not decrease.

The transitional costs of creating capacity in general practice by shifting activity such as common ailments, self-care to wider primary care providers needs to be considered.

Finally, the impact of any new national contract for general practice and the wider primary care system will need to be considered once detailed are released.
## 4.8 Delivery risks

The table below sets out the risks associated with the delivery of the new care model and any associated mitigations that the East London system will need to manage.

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk Likelihood</th>
<th>Risk Impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perverse incentives for change may be observed if the payment for services does not clearly follow the patient</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Consider as part of implementation planning in line with payment innovation work</td>
</tr>
<tr>
<td>Workforce supply will not be sufficient to implement new care model and meet future demand</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Launch a joint recruitment strategy across East London health and social care providers</td>
</tr>
<tr>
<td>Lack of co-ownership, development and co-production of the strategy and implementation plan</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Further development of strategy at Board development sessions in December 2015</td>
</tr>
<tr>
<td>Lack of ownership in the form of a defined clinical lead for primary care improvement within each borough</td>
<td>5</td>
<td>3</td>
<td>15</td>
<td>Consider appointment of a clinical lead/medical director to take forward primary care transformation in each borough</td>
</tr>
<tr>
<td>Provider development and readiness: 1. Lack of confidence in provider bidding contracts 2. Slow progress in bidding at scale 3. Low levels of network working</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>CCG led provider OD development programme with appropriate infrastructure, management and governance in place to help them succeed.</td>
</tr>
<tr>
<td>Potential conflict of interest between CCG Boards and provider networks</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Each CCG and provider network to ensure robust governance arrangements are in place</td>
</tr>
<tr>
<td>Specifics of pathway redesign programme requirements of primary care due to shifts of activity are not yet known</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>Assumptions of anticipated shift made in modelling assessments. Joint implementation planning post-pathway redesign sessions will be necessary</td>
</tr>
</tbody>
</table>
4.9 Next steps

The table below details the milestones that will form the next steps associated with this transformational scheme:

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test and agree plans</td>
<td>With Patient and Public Reference Group (November 15) and Governing Body development sessions</td>
<td>December 2015-February 2016</td>
</tr>
<tr>
<td>Define local commissioning strategies</td>
<td>Understand what will be delivered at network, local, regional and national level</td>
<td>January 2016</td>
</tr>
<tr>
<td>Further finance and activity modelling</td>
<td>To further validate assumptions and incorporate capital costs derived from interim borough estates strategies (December 15). To include an appointment scheduling workshop</td>
<td>February 2016</td>
</tr>
<tr>
<td>Approach to implementation agreed (implementation project initiation document)</td>
<td>Detailing approach to implementation and indicative timescales aligned with local, regional and national requirements</td>
<td>March 2016</td>
</tr>
<tr>
<td>Outline business case drafted</td>
<td>To make the case and enable any financial investment required to be signed off</td>
<td>April 2016</td>
</tr>
<tr>
<td>Initial workforce impact assessment complete</td>
<td>Initial understanding of complexities scoped including the likelihood of any required workforce consultation related to consequences of change for staff terms and conditions</td>
<td>April 2016</td>
</tr>
</tbody>
</table>

In addition, the following tasks will be carried out by commissioning organisations:

**Accessible, proactive and co-ordinated care**

- CCGs will ensure that robust plans are in place to align local strategies to the London framework with key timeframes for deliverables being agreed and shared.
- The scope and outputs of proactive care and co-ordinated care models will be defined in alignment with local integrated care strategies.
Commissioning

- Local commissioners need to explicitly determine their future commissioning plans. This will include what practices/groups of practices will provide what range of services including where economies of scale will be encouraged.
- CCGs will work to ensure they support providers/federations to be mature and confident by November 2016 through continued provider development or enabling providers to tender and bid for contracts.
- CCGs will use contractual leavers to ensure contractors are abiding by contractual obligations.
- CCGs will commission care from practices which work with multidisciplinary teams and practices that give patients a choice of a male or female healthcare professionals.

Enablers

- Services will be commissioned from practices that are willing to work collaboratively in networks, operating from fit-for-purpose buildings where IT supports delivery of care and system-wide working.
- Commissioners in each borough will determine the optimum number of practices including how many primary care hubs are required and a timescale for implementation.
- Estates plan will be informed by the TST commissioning strategy; and any estates investment costs will be calculated and assessed based on the publication of interim borough estates plans in December 2015.
- CCG will seek to maximise current resources in terms of access. For example void capacity will be proactively reduced and plans will be put in place to maximise capacity and economies of scale in back office functions.
- CCGs will create a joint recruitment strategy across East London to manage the workforce challenges across primary care and the community/hospital interface.
- CCGs will identify what level of extended hours coverage is required and commission necessary access to services which aid the implementation of the Urgent Care TST scheme.
- CCGs will work with local populations and clinical colleges to promote the opportunities and advantages of working in East London.

Quality

- CCGs will agree on a set of outcome and quality metrics that provide the ability to track the successful implementation of this strategy, including a performance dashboard across the three boroughs. This dashboard will focus on clinical pathway improvement, clinical indicators, patient experience and satisfaction, staff satisfaction as well as provider performance metrics.
Engagement

The need for any public or staff consultation will depend on the number practices that re-locate/merge or new procurements and will be locally led; any shift in employment status. However further engagement on this strategy will be carried out with:

- TST Patient and Public Representative Group
- CCG Board Meetings
- Primary Care Commissioning Committees at each CCG
- Primary Care Advisory Committee for WEL
- Primary Care Board for WEL
- Primary Care Development Committee at each CCG
- Locality meetings within each borough
- Primary care transformation workshops (across WEL and CCG specific)
- With partners including NHS England, Local Authorities and Public Health teams, JOSC, local MPs and Healthwatch, Public Health/LA
- Local Medical Committees
- Primary care providers
5: Establish surgical hubs, including interventional radiology

5.1 The case for change

Emergency and elective surgical services are delivered at three Barts Health NHS Hospital Trust sites in East London: Newham Hospital, the Royal London Hospital and Whipps Cross University Hospital. Each of these sites delivers varying levels of secondary care and specialist surgical services. Surgical services are also delivered at St Bartholomew’s Hospital, however, this is dedicated to cancer and cardiac specialised services.

Although there are examples of parts of the system working well, patients are receiving variable standards of care and the current configuration of services is not the most effective use of surgical resources. For example we know that:

- The quality of care can be improved. Currently, because each of the three main sites delivers similar elective services, surgeons in some hospitals see low numbers of patients despite a growing body of evidence showing that higher numbers of patients are associated with better outcomes.

- The lack of dedicated short stay surgical facilities with enhanced recovery pathways means that patients are staying longer in hospital than necessary.

- Emergency surgery across sites is not optimised and this sometimes means delays for non-life threatening emergency surgery.

- The high bed occupancy and difficulty in separating emergency and elective surgical services (including a lack of ring-fenced beds) contributes to, in some specialities, up to 20% of elective operations being cancelled.

- Many patients are waiting too long for operations and performance against referral to treatment times is poor in many specialities at Barts Health.

- Some people are waiting longer than necessary in hospital before an operation.

- Not all sites meet the paediatric general emergency surgery standards.

- Whipps Cross Hospital and Newham Hospital both fail to meet London Quality Standards targets for access to interventional radiology for critical and near-critical patients. This is in part due to high bed occupancy at the Royal London Hospital meaning high dependency unite beds are not available.

We also know that a large number of non-complex operations take place at the Royal London Hospital, causing high bed occupancy. These could be delivered more effectively at Whipps Cross Hospital or Newham Hospital and also allow the Royal London Hospital to free up capacity in order to treat more of the sickest patients and most complex cases.

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75 Surgenet data. Barts Health internal performance metrics Jan-Jul 2015


This variation in accessing high quality surgical care across East London is not acceptable. Given the opportunity to work at scale across the three sites as Barts Health, there is a chance to look at the way services are delivered in order to improve patient safety and improve outcomes, better using capacity to deliver surgery more effectively across East London.

As part of developing a new model of care we have considered how changes to both emergency and elective surgical services can help us ensure we make the most effective, responsible and sustainable use of our limited specialist resources (both people and equipment).

5.2 Model of care

Hospitals, such as those within Barts Health, will need to work effectively in networks to deliver safer, more sustainable and higher quality care. Working in networks will mean that most care is delivered locally, with patients only travelling further when it leads to better outcomes. As demonstrated in the Transforming Services Changing Lives Case for Change, changing the configuration of surgical services across East London would maximise patient safety and contribute to making the services more sustainable. A new configuration of services would:

- ensure more low risk surgical procedures are taking place at residents’ local hospitals
- deliver pre-operative care closer to people’s homes
- consolidate some surgical procedures at specialist hubs where it improves outcomes, provides safer services and makes provision more sustainable
- strengthen cross-site working and improve inter-hospital transfer arrangements
- develop a safer emergency surgery model, strengthening network and triage arrangements across all sites.

For example, in the future, people living in Newham with breast cancer could be able to have all their outpatient and pre-operative assessments with their surgical team at Newham Hospital, before complex surgery taking place at the Barts Cancer Centre using the latest equipment and surgical techniques. This differs from current arrangements which would usually see patients travel all the way to Barts Cancer Centre for each stage of their treatment.

These changes would also allow the Royal London Hospital to free up capacity from less complex cases in order to treat more of the sickest patients and most complex cases.

To do this we want to establish surgical hubs at each Barts Health hospital site that work together in networks.

Enhanced surgical care through surgical hubs and an improved emergency network

These high quality surgical hubs would operate in networks, to provide safer, less variable care by the right person, at the right time.

Describing surgical services as ‘core’, ‘core plus’, and ‘complex’ provides a way of describing how services should be provided across East London.
For example:

‘Core’ services are surgical services which support emergency, medical and maternity care and should be available on all sites. They also include less complex, elective surgical procedures that can be run in dedicated short stay, day case or outpatient facilities.

‘Core plus’ services are surgical services which require a degree of specialisation and/or resources. They require a concentration of the specialist workforce and dedicated capacity in order for care to be delivered safely and sustainably. All three hospitals will have a core plus service, but it will be different at each hospital.

‘Complex’ services are surgical services which are required to support the treatment of complex cases, such as complex cancer or trauma. Clinical interdependencies and the input of multiple specialities are crucial to optimise safety and patient outcomes.

As part of this model, each site would host core services and different combinations of core plus and specialised hub functions. For example, we have already been piloting Newham Hospital as a core-plus, specialised hub for arthroplasty (hip and knee) surgery.

**Proposed segmentation of surgical services**

Through a combination of core and core plus services, all sites would maintain the capacity and capability to support emergency and maternity services safely, as well as taking advantage of the appropriate consolidation of services:

- Services would see more patients, which would lead to more effective care with dedicated specialist consultant cover
- Capacity would be freed up at the Royal London to deliver emergency surgical interventions without delays
- There would be more experienced staff with dedicated resources for enhanced recovery and higher day case and outpatient rates (reducing unnecessary stays in hospital)
• Specialist equipment could be used more effectively to deliver higher day case rates e.g. use of interventional radiology for less invasive procedures

• Ability to meet royal college and clinical quality standards across sites e.g. Standards for non-specialist emergency surgical care of children

• Higher numbers of procedures enable better consistency of planning and utilisation, and fewer cancellations

• The potential to provide dedicated pre- and post-operative care that improves shared decision making and pre-operative quality of care. This also safely reduces length of stay

• Larger patient list sizes across the organisation also boost research, learning and teaching opportunities.

**Approach to developing surgical hubs: core, core-plus, complex**

In order to take this work forward we will need to understand which surgical services can be consolidated in order to deliver care more efficiently and improve patient outcomes.

To do this, surgical specialties have been considered against site-based capabilities, equipment, facilities and capacity; the likelihood of an improvement to outcomes and efficiencies; and to better distribute demand across sites.

The benefits of any consolidation of services will need to be balanced against the following key considerations:

- The impact of changes on the way people access services especially vulnerable or frail patients
- If consolidation would undermine the delivery of high quality local emergency and maternity services
- If there are specialties where patient numbers are relatively low and splitting elective and emergency procedures would result in clinical teams not treating sufficient numbers to maintain their skills; or if there are specialties which require the same specialist equipment or facilities for both elective and emergency activity and patient numbers are too low for a split to be cost-effective
- If there are co-dependencies between specialties and, for the above reasons, one of those specialties must be located on one particular site only.

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78Royal College of Surgeons 2015, National Standards for Non-Specialist Emergency Surgical Care for Children
The potential for consolidating certain types of ‘core plus’ procedures

N.B. The Healthcare for London clinical dependencies framework was used as a framework – see Elective surgical hubs appendix 1

What will this mean for the potential future set up of services?

Over the next six months we will be working with clinicians and patients to develop these plans. This will include detailed understanding of how surgical specialties fit into core; core-plus and complex. We would also be able to understand in more detail the improvements in outcomes we would expect to achieve.

This work will build on work that has already begun in understanding how services may have to be improved and enhanced at sites with regards to new royal college guidance. For example we know that work has taken place to start to understand how we can meet new Royal College of Surgeons guidance on National Standards for Non-Specialist Emergency Surgical Care for Children. A potential view of what a future set up of services might look like across sites can be seen overleaf. Over the next six months we will be working to test and enhance this.

Once we have completed this work we would fully engage with patients and the public on these changes.

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Royal College of Surgeons 2015, National Standards for Non-Specialist Emergency Surgical Care for Children
N.B. As St Bartholomew’s Hospital does not have an A&E - it does not have a ‘core’ surgical offer.

In the future we also know that for selected specialties we would also aim to provide additional interventional radiology capacity to undertake interventional radiology in place of traditional surgery. This would enable us to deliver more day-case treatments and improve the patient experience. To do this we would need to invest in more specialist equipment and consider the clinical interdependencies that would bring the most benefits for patients.

We also need to make sure that the new set up of services is suitable for vulnerable and older people. We need to make sure transport issues for frail elderly are fully considered as well as other vulnerable groups.

**Formalise the network model for high quality emergency surgery**

Our proposal for surgical hubs would also provide each acute site with improved consultant cover to provide effective cross site emergency and on-call cover to deliver 24/7 A&E and maternity services.

Evidence shows that surgery should not be carried out at night unless a patient’s life or limb is threatened. Therefore under these proposals Newham Hospital and Whipps Cross Hospital would carry out onsite emergency surgery for 12-16 hours a day, with emergency surgery for life-threatening conditions outside these hours provided by Royal London Hospital. This will ultimately improve clinical outcomes and save lives.

Therefore, a key ‘core’ requirement at each site is the capacity and capability to surgically triage patients, stabilising them and transferring complex cases to the site that will deliver the best outcome for patients. This represents a strengthening and formalising of how our sites currently work (see also the network emergency care model as outlined in the emergency care initiative - part 3, section 6). Clear protocols would be required for the management of
patients who need a surgical intervention that cannot be provided on a timely basis onsite, including use of National Confidential Enquiry into Patient Outcome and Death (NCEPOD) lists to improve outcomes. These operating lists differentiate between emergency surgery where patients can be safely stabilised and scheduled into theatre and where immediate surgery must take place to save life or limb. This means hospitals can plan more effectively for scheduled trauma lists surgery. This has been shown to improve outcomes, while ensuring that there is capacity available for life threatening emergency surgery.

Improved emergency care would be enabled by:

- redesigning and embedding new surgical on-call rotas, remote and network arrangements to ensure safe and effective cover 24/7 across sites
- better use of technology to deliver more effective cross-site specialist on-call arrangements
- using NCEPOD lists as effectively as possible to maximise outcomes for patients.

These changes would enable us to effectively increase trauma and emergency theatre capacity at the Royal London Hospital to match demand and complexity to ensure the best outcomes for patients needing emergency surgical intervention.

**Improved pathways to improve care**

We know we can improve the whole of a patient’s experience of treatment as well as reducing unnecessary cancellations by improving the processes before and after surgery.

As part of developing surgical hubs we need to ensure that pre- and post-operative pathways are improved. This would ensure that we deliver pre-operative care closer to home and coordinated re-ablement and recovery to get people home quickly and safely.

Our proposed model of care includes a single point of referral across Barts Health sites. This aims to ensure timely access to specialist consultant advice while working across site boundaries. The model includes GPs and community nursing staff in the delivery of pre- and post-operative care.

The new model aims to improve local surgical provision and reduce the distance people travel for pre- and post-operative care. Many people would receive more of their care at their local hospital and would be likely to travel less.

We want to deliver pre-operative care closer to home where appropriate, using technology where possible, including straight to test pathways where appropriate. We want to develop one-stop multidisciplinary clinics, including social care assessments for higher complexity patients and run these at each site where sustainable. This would mean patients only need to travel for tests when specialist equipment or expertise is required.

There is an opportunity to use this time with patients to deliver important health messages and interventions. Throughout the pathway there will be an improved focus on prevention, ensuring that this is built into clinical models, risk stratification and staff training. This should include effective onward referral and signposting to third sector and social support services that can improve people’s health outcomes.

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80 Straight to test pathways allow a fast track service where patients undertake key diagnostic procedures before their appointment with a hospital consultant.
The proposed perioperative model

We will progress this proposal by:

- implementing single points of referral for specialities across site
- implementing pre-operative one stop clinics across all sites to deliver care closer to people’s homes and reduce travel
- developing multi-agency pre-operative processes for higher risk patients
- standardising risk-profiling across sites
- developing pre-operative processes closer to home for lower risk patients
- maximising the use of straight to test pathways.

Expected benefits of surgical hubs

Changing the configurations of surgical services across East London will maximise patient safety and contribute to making our services more sustainable.

This change will also allow better network working with other NHS trusts across London through clearer access to a strengthened specialist hubs and world class tertiary centres.

The expected benefits of making these changes are:

- Improved safety and clinical outcomes
- Fewer avoidable cancelled operations
- A better experience of care, closer to home wherever possible
- More proactive support to recuperate at home and reduced length of stay in hospital
- More efficient use of theatres and our specialist workforce
- Better team working, support and training opportunities.
Workforce of the future

The new model of care aims to maximise the use of workforce skills and expertise. Each element of the model requires changes to the way staff work. The key workforce considerations of each of the model’s elements are:

**Workforce implications of core services**

Day case nursing teams need to be re-established as a dedicated resource. It is envisaged that this could be achieved by better utilisation of existing staff; the intention is not to seek new or additional roles for this element of the strategy. The nursing roles would prove attractive as they offer a regular day case-only working pattern. However, Consultants may choose to do day case sessions on a rota basis to ensure that they are also able to maintain their skills and expertise in other, more complex elective procedures.

Key workforce requirements for this element of the model will be the need for revised on-call rotas, adequate numbers of anaesthetists, and a requirement for all sites to have appropriate paediatric capability, as without this all paediatric cases would need to be referred to the Royal London, which is not in line with national standards.

All sites will require training to ensure that they are equally capable of non-complex emergency surgery for both adults and children.

**Workforce implications of core plus services**

There is a recognised shortage of highly qualified specialist staff, and this element of the model seeks to consolidate existing staff onto one site per specialism, with patients streamed appropriately to the correct service in order to access this level of specialist care. This would provide improved patient outcomes and enable throughput of complex cases to be better and more safely managed.

The separation of elective and day case procedures and streaming of complex surgery to core-plus hubs would also enable consultants to have better access to diagnostics and interventional radiology resources for elective procedures, thereby releasing capacity through the improved use of technology. The workforce implications of the sub-specialty hubs are difficult to determine in detail until the configuration of those hubs has been agreed; the priority at this stage is to build the model and system, and the implications for staffing can then be determined as part of the implementation phase. If particular hubs are identified in growth areas, with much higher patient numbers, workforce plans may need to include the development of new roles such as physician’s associates to help meet demand.

**Complex and emergency services**

The reconfiguration of core and core plus surgery should result in increased trauma and emergency theatre capacity to match the growing demand and complexity of cases, and a more sustainable use of skilled expert staff across the system. The provision of intensive care unit recovery support is essential to support the core plus surgical offering\(^81\).

The focus on the development of specialist teams and reconfiguration of work flows means that it should be possible to staff the new complex and emergency care model within existing resources and reduce reliance on temporary staffing. However, this

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\(^{81}\) LQS standards 1 and 4 will need to be met in such settings; access to a consultant intensivist within one hour on a 24/7 basis. Standard 17 will also be required to be met; a minimum of 70% of nursing staff in ITU to hold a post-graduate intensive care qualification.
assumes that posts can be filled to establishment levels. Where this is not the case consideration may be given to the development of new and appropriate roles to assist with skill mixing e.g. physician’s associates role in minor and simple surgical services.

Improvements to pre- and post-operative care
Integral to the success of the strategy is the requirement to release capacity within surgery by making changes to the way in which pre- and post-operative care and re-ablement are delivered, with this being managed closer to home in community settings instead of via the traditional model of attendance at hospital based clinics. It is estimated that 70% of patients do not require their pre-operative assessment to be carried out in a hospital setting, which could be delivered in the community.

This shift in activity would inevitably have an impact on primary care service configuration and demand; to establish and manage community based pre-operative one-stop multidisciplinary team clinics, and on the wider system in terms of ensuring capability to deliver diagnostic testing via new ‘straight to test’ pathways. It is anticipated that the clinics would have a local authority/social service presence which needs to be quantified to determine the workforce implications for that sector. Community staff would be required to perform a range of test and assessments, and allied health professionals would be required for re-ablement (occupational therapy and physiotherapy). Further work is required to determine the future model, and the workforce implications will depend on mode of delivery and model agreed. It is likely however that there will be a need to transfer some existing staff delivering these services into the community and to recruit and/or upskill some staff to meet the workforce requirements.

Workforce next steps
The known additional workforce investment is detailed below. However, more validation work is needed. The next steps in taking forward changes to the workforce are outlined below:

Existing roles: As part of the implementation planning we must have a) a plan to review the current working practices of all our staff groups, based on the need to establish short stay, surgical day case and outpatient provision and b) decisions made about the configuration of ‘core plus’ services to be hosted on specific sites. Where necessary, we will consider changes to working patterns and/or bases in order to deliver high quality services and meet London Quality Standards (LQS) requirements, which may include review of consultant job plans and changes to terms that require further consultation.

Multi-disciplinary working: As part of the implementation planning we aim to have a clear plan to create dedicated specialist teams to deliver ‘core plus’ and ‘complex’ surgical procedures within sub-specialist hubs i.e. consultant-led multidisciplinary teams working together to deliver on moderately or highly complex surgical operations. This will require the consolidation of roles currently aligned to surgery within the existing workforce into a more clearly defined multidisciplinary model. This should improve patient outcomes and enable staff to develop, learn and gain additional experience, which may also support improved recruitment and retention to the teams.

Training: By 2017 we aim to have produced a training and education plan which will undertake to upskill GPs, community nursing, allied health professionals and support staff in the delivery of pre-operative care and assessment and post-operative care and re-ablement support. This will enable patients to maximise opportunities to
access the care they require closer to home, with only the surgical procedure itself being undertaken in the hospital setting. This will support the provision of additional surgical capacity.

Collaborative working will be required with Health Education England (HEE), Health Education North Central and East London (HENCEL) and our Community Education Providers Networks (CEPNs) and other relevant regional and national agencies to ensure that proposals are developed which are aligned to national, Londonwide and other relevant policies and standards.

Organisational development

We know that there needs to be support provided to staff to work in new ways. This is summarised below, with total costs summarised in part 3, section 5.6:

- Shift current behaviours and attitudes to create flexible pools of high performing teams for each surgical site to enable enhanced recovery (three year programme)
- Supporting consultants in expanding their roles (four year programme)
- Support the design and engagement on interventional radiology model to underpin surgical hubs (one year programme).

5.3 Engagement

The pilot of the orthopaedic hub at the Newham Gateway centre was agreed at the clinical strategy group (WEL CCGs) on the 17 September 2014 following work that was reviewed at the clinical services review panel and fully supported following engagement with CCGs. This was presented at the INEL JOSC in early 2015.

- Regular meetings and with the clinical lead for surgery at Barts Health, clinical lead for surgery at Newham CCG and the productive theatres lead at Barts Health
- Meetings with; general manager for trauma and orthopaedics, acute clinical lead for Newham and Waltham Forest CCGs, lead surgeon at Newham Hospital, consultant urologist at Whipps Cross Hospital, chair of Tower Hamlets CCG (also the clinical lead for TST) and finance and performance teams at Barts Health
- Emerging surgery strategy shared with patient representatives at the TST Patient and Public Reference Group (PPRG) in July. Invitees include patient representatives from CCGs and Healthwatch across north east London, Barts Health, Homerton Hospital, ELFT and NELFT.
- Attendance at surgical specialty team meetings at Barts Health across the hospital sites (urology, dentistry/maxillo facial, general surgery).
- Workshop to develop surgery strategy (15 January) invitees included:
  - Clinical and managerial leads from Barts Health including representatives from across the sites, for: breast surgery, colorectal, ear nose and throat, general surgery, orthopaedics, urology and anaesthetics; the surgery clinical academic group lead pharmacist and primary care lead
  - Leads for colorectal and orthopaedic surgery from Homerton Hospital
  - Clinical leads from Newham, Tower Hamlets and Waltham Forest CCGs
  - Acute care lead from Newham and Waltham Forest CCGs
  - Two patients, one of whom was also a patient representative
5.4 Outcomes the change will achieve

The above model of care is intended to achieve the following outcomes:

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective length of stay (LOS) improvement</td>
<td>LOS improvement of 10% across all elective surgical inpatients</td>
</tr>
<tr>
<td>Improvement in theatre efficiency</td>
<td>Improved efficiency by 12%</td>
</tr>
<tr>
<td>Reduction in on-the-day cancellations</td>
<td>To top 10% peer performance</td>
</tr>
<tr>
<td>Improvement in day case rates (based on the British association of day case surgeons basket of procedures)(^{82})</td>
<td>To top 10% peer performance</td>
</tr>
</tbody>
</table>

5.5 Investment costs

In order to implement the model of care the following investments are required. This includes capital requirements, workforce investment, project implementation costs, organisational development (OD) costs and investments in IT.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Capital costs inc.</td>
<td>£0.82m</td>
<td>£1.4m</td>
<td>£1.4m</td>
<td>£1.4m</td>
<td>£1.4m</td>
<td>£6.44m</td>
</tr>
<tr>
<td>capital revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workforce</td>
<td>£0.09m</td>
<td>£1.25m</td>
<td>£1.04m</td>
<td>£1.04m</td>
<td>£3.41m</td>
<td></td>
</tr>
<tr>
<td>(including project</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>management, procurement etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>OD costs</td>
<td>£0.16m</td>
<td>£0.15m</td>
<td>£0.15m</td>
<td>£0.05m</td>
<td>£0.51m</td>
<td></td>
</tr>
</tbody>
</table>

5.6 Impact on activity and revenue

Improved length of stay

The new model of care will enable to treat many more patients with a small investment in extra staff and one additional theatre (detailed in part 3, section 5.5). The reduction in elective length of stay would lead to a reduction of 8,593 bed days required in the future to deliver a larger amount of surgical activity. This is the equivalent to a reduction of 24 beds that could be used to treat the growing demand.

The surgical length of stay reduction scheme will reduce elective length of stay by 10% in 2020/21.

This scheme only applies to the 3 main sites at Barts Health NHS Trust (Whipps Cross, Newham Hospital and The Royal London).

In 2020/21 this scheme will reduce elective bed days by 5,812 which equates to approximately 16 beds (assuming 100% occupancy).

The reduction is slightly greater than the expected increase in bed days due to growth.

This extra capacity would provide Barts Health with the opportunity to tackle its backlog, or to treat other patients on the waiting list more quickly.

More work is needed to understand the best use of this capacity for patients and the health system overall. Using this capacity for elective backlog would reduce the amount of work that Barts Health is outsourcing to other providers and increase the revenue for the trust.

Theatre productivity improvement

The new model of care would improve theatre utilisation over the five years from 45% to 56.8%.

This estimate has been developed through detailed conversations with surgical leads in all specialties by looking at current average surgical lists and practical improvements that could be achieved through the new clinical models, including:

- improved scheduling and booking
- reduction in late starts
• reduction in patients not attending
• improvements in capabilities through specialisation and higher volumes

Using the activity baseline of 2014/15 and improving theatre productivity to 56.8% provides the equivalent of a real terms increase of 26.2% theatre capacity across sites above current activity levels. This increase is more than the aggregate forecast growth in demand over the next five years of 2.8% cumulative growth per year (demographic and non-demographic growth over the five years is the equivalent of 14.8% growth). This means that there would be no need to build new theatre capacity purely to deal with additional population growth.

However, there is a need to do more analysis as additional capacity may be needed for the following reasons:

• **Capacity across sites not aligned with growth** – faster population growth or change in one borough may require a site to boost capacity.

• **Opportunity to bring in more work** – in delivering best in class services, core-plus hubs may treat patients from a wider catchment area than East London CCGs. This is likely to mean extra capacity is needed.

• **Need to flex capacity to deliver redesign and new models of care** – service changes to deliver these new models of care will require some excess capacity in order to double run some services and ensure changes can happen safely, without harm or delays to patients.

• **Specialist theatres or equipment** – there may be a need to develop capacity in certain type of theatres i.e. specialist day care facilities or lead-lined rooms for interventional radiology in order to keep pace with advances in clinical practice and take advantage of the latest techniques.

Due to this uncertainty, and in order to ensure that savings portrayed are not overly optimistic, we have included the investment costs of one theatre alongside the refurbishment of wards requiring urgent maintenance.

To refine this figure, there is a need to conduct a more detailed analysis of theatre demand and capacity; this is a key part of the next steps outlined in part 3, section 5.9.

**Financial impact including sensitivity analysis**

The changes free up capacity at Barts Health through improved productivity. After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £0.2m to £5.7m over a five year period.

This does not take into account the additional revenue benefits to the provider realised through better use of existing capacity.

**Additional finance modelling assumptions**

With the exception of increasing the interventional radiology workforce and some additional theatre teams, the surgical hubs do not require additional workforce as the assumption is that current teams could deliver the future model of care.
The exact level of savings to the system and impact on revenue for Barts Health are dependent on decisions of how any freed up capacity is used. Further financial validation will be required as part of the business case stage.

### 5.7 System commercial considerations and transitional support required

The key commercial considerations in taking this work forward are:

- tendering issues around any new build or major works i.e. proposed new theatres/refurbishments
- potential investment in community services will be required in order to improve pre-operative and post-operative pathways
- new models of care will improve Barts Health’s ability to undertake surgery – and contribute to the 18 week referral backlog – this must be managed in a sustainable way.

### 5.8 Delivery risks

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk Likelihood</th>
<th>Risk Impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| 1 Risk of misalignment with Barts Health (BH) internal improvement work and future capacity planning, which could mean short term changes undermine longer term vision | 3               | 3           | 9           | - Ongoing work with BH productive theatres programme and referral to treatment turnaround  
- Barts director identified to lead work  
- Meetings with general managers to be arranged  
- New BH resource in place to work through next stages of capacity and demand matching and analysis |
| 2 Lack of CCG engagement and support delays or prevents changes                   | 2               | 4           | 8           | - Ongoing efforts to engage with CCGs. Clinical leads from CCGs involved in planning and strategy development  
- Continued engagement of topic at stakeholder events |
| 3 Lack of patient engagement delays or prevents changes                           | 3               | 4           | 12          | - Ongoing work with communications team to engage patients and build narrative for change  
- Workplan to take into                                                                 |

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5.9 **Next Steps**

In order to take this work forward we want to work with clinicians and patients to develop clear plans to create high performing surgical hubs. This will require:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Outline</th>
<th>Time scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work to develop detailed clinical plans</td>
<td>Working with clinicians and patients to develop detailed future plans. This will include detailed understanding of how surgical specialties fit into core; core-plus and complex.</td>
<td>Feb – July 2016</td>
</tr>
<tr>
<td>Detailed demand and capacity work</td>
<td>Work to develop detailed future plan of theatre capacity across site and by speciality to ensure feasibility of any proposals.</td>
<td>Feb – July 2016</td>
</tr>
<tr>
<td>Ongoing public and patient engagement</td>
<td>Work with TST PPRG and Healthwatch to develop proposals that take into account patient perspectives.</td>
<td>Feb – July 2016</td>
</tr>
<tr>
<td>Core provision and emergency network</td>
<td>Work to boost local ‘core’ surgical provision and ensure high quality local general surgical provision across site (including non-complex paediatric). Work to formalise emergency surgical network across Barts Health sites.</td>
<td>March 2016 (ongoing)</td>
</tr>
<tr>
<td>Further engagement on</td>
<td>Complete impact assessment in line with patient and public concerns and conduct appropriate consultation.</td>
<td>July 2016</td>
</tr>
<tr>
<td>detailed proposals</td>
<td></td>
<td>2016/2017</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Potential expansion of surgical capacity</td>
<td>Following demand and capacity analysis, potential business cases for expansion of appropriate surgical capacity e.g. refurbishment of Plane Tree Centre(^{85}) and potential new build of theatre at Newham.</td>
<td></td>
</tr>
</tbody>
</table>

\(^{85}\) Plane Tree Day Case Surgical centre is at Whipps Cross Hospital and has the capability to act as a stand-alone day case surgical facility
### Acute emergency and obstetric services dependency framework

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Key</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetics</td>
<td>R+</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>G</td>
</tr>
<tr>
<td>Paediatric Emergency Department</td>
<td>G</td>
</tr>
<tr>
<td>Acute Medical Opinion/Assessment (&lt;72hrs)</td>
<td>R+</td>
</tr>
<tr>
<td>Specialist Medical Opinion</td>
<td>A+</td>
</tr>
<tr>
<td>General Specialist Medical Inpatients (&gt;72hrs)</td>
<td>A+</td>
</tr>
<tr>
<td>Paediatric Emergency Medical Opinion/Assessment</td>
<td>G</td>
</tr>
<tr>
<td>Paediatric Resus</td>
<td>G</td>
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<tr>
<td>Paediatric Inpatients</td>
<td>A+</td>
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<tr>
<td>Acute/Emergency General Surgical Opinion/Assessment</td>
<td>R+</td>
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<tr>
<td>Acute/Emergency General Surgical Operation</td>
<td>A+</td>
</tr>
<tr>
<td>Acute General Surgical Admission</td>
<td>G</td>
</tr>
<tr>
<td>Elective Inpatient Surgery</td>
<td>G</td>
</tr>
<tr>
<td>Paediatric Emergency General Surgical Opinion</td>
<td>A+</td>
</tr>
<tr>
<td>Paediatric Emergency General Surgical Operation</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Opinion (Gynaecology)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Opinion (Orthopaedics/Trauma)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Opinion (Urology)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Opinion (Vascular)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Opinion (ENT)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Operation (Gynaecology)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Operation (Orthopaedics/Trauma)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Operation (Urology)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Operation (Vascular)</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Surgery Specialty Operation (ENT)</td>
<td>A+</td>
</tr>
<tr>
<td>Paediatric Emergency Specialty Operation*</td>
<td>A+</td>
</tr>
<tr>
<td>Paediatric Emergency Specialty Operation*</td>
<td>A+</td>
</tr>
<tr>
<td>Emergency Imaging and Reporting***</td>
<td>R+</td>
</tr>
<tr>
<td>Emergency Interventional Radiology***</td>
<td>R+</td>
</tr>
<tr>
<td>Emergency Endoscopy (Incl Therapeutic)</td>
<td>A+</td>
</tr>
<tr>
<td>Acute Pathology (Laboratory Assessment Services)</td>
<td>A+</td>
</tr>
<tr>
<td>Haematology/Transfusion/Blood Bank</td>
<td>R+</td>
</tr>
<tr>
<td>Echocardiography</td>
<td>A+</td>
</tr>
<tr>
<td>Cardiac Angiography</td>
<td>A+</td>
</tr>
<tr>
<td>Adult Critical Care Opinion/Intervention (Levels 2 and 3)</td>
<td>R+</td>
</tr>
<tr>
<td>Adult Critical Care Admission/Access (Levels 2 and 3)</td>
<td>R+</td>
</tr>
<tr>
<td>Tertiary Critical Care Access</td>
<td>A+</td>
</tr>
<tr>
<td>Paediatric Critical Care Opinion and Assessment (Incl. Anaesthetics)</td>
<td>G</td>
</tr>
<tr>
<td>Paediatric Critical Care Access</td>
<td>G</td>
</tr>
<tr>
<td>Neonatal Care</td>
<td>G</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>G</td>
</tr>
<tr>
<td>Acute Mental Health Liaison Services</td>
<td>A+</td>
</tr>
<tr>
<td>Safeguarding Level 3 Provision</td>
<td>A+</td>
</tr>
</tbody>
</table>

* Specialty includes gynaecology, orthopaedics, vascular and urology

** Emergency imaging includes CT and ultrasound

*** Where interventional radiology services are not available onsite, time from decision to transfer to arriving at receiving hospital should be no more than 1 hour. Access for critical patients, 1 hours. Non-critical, 4 hours.

### Notes:

This table combines the individual interdependency frameworks of each service area reviewed as part of the Quality and Safety programme (listed to the right).

For any of the services shown to the right, read down the column to see how dependent they are on the services listed below. Example: Obstetrics is dependent on having the immediate availability of acute medical opinion/assessment.

<table>
<thead>
<tr>
<th>Key</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>R+</td>
<td>Needs to be immediately available and co-located</td>
</tr>
<tr>
<td>T</td>
<td>Needs to be available in less than an hour and could be provided in an effective network</td>
</tr>
<tr>
<td>A+</td>
<td>Needs to be available/accessible within 4hrs</td>
</tr>
<tr>
<td>A</td>
<td>Needs to be available/accessible within 24hrs</td>
</tr>
<tr>
<td>G</td>
<td>No direct dependency</td>
</tr>
</tbody>
</table>
6: Establish acute care hubs at each site

6.1 The case for change

The Transforming Services Changing Lives (TSCL) Case for Change showed that the current emergency care system is unsustainable. The work we have completed has shown that:

- our current system of urgent and emergency care is complex and confusing
- people are not well enough supported to manage their own conditions
- emergency departments are struggling to meet and maintain the 95% target for patients to be seen and discharged within four hours
- too many people are admitted to a hospital ward when they could be better cared for elsewhere. New ways of working such as ambulatory care provide appropriate care to patients without admission. Clinicians have told us that this could be up to 15% of the patients that are currently admitted to a ward
- patients often remain in hospital beds longer than they need to or when they could receive appropriate care outside of hospital. The average length of stay of a patient in Barts Health NHS Trust is 0.5 days longer when compared to peers
- two emergency departments do not meet the London Quality Standards for consultant cover at the evening or weekend. There are national shortages in supply of emergency medicine clinicians; the specialty shows the highest vacancy rate across England (15%).

On top of current operational issues, the challenges are only going to become more severe. We are expecting an additional 270,000 people to be living in East London in the next 20 years. This rising demand, combined with the planned closure of the emergency department at King George Hospital (KGH), means there is likely to be a rise in the numbers of people coming to Barts Health emergency departments of around 93,000 per year by 2020.

We know that emergency departments should be for emergencies only, yet we know from local health data that up to 21% of those who attend A&E, but who are not admitted, require no significant treatment. Our confusing urgent care system contributes to this problem. The changes we will make to urgent care (outlined in part 3, section 2) aim to address this challenge.

However, even with the successful delivery of improvements to our urgent care system, our growing population means that in five years our emergency departments will be seeing as many people as they do today. But, if the urgent care system treats more people with minor problems, in future patients who turn up at emergency departments are likely to be sicker.

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86 CKHS Dataset, last accessed 13/10/2015. Years are July to July calendar years, 11-12 only based on partial data (April – July 2012)
87 London Health Programmes. Quality and Safety Programme Acute medicine and emergency general surgery
www.nhs.uk/NHSEngland/keogh-review/Documents/UECR_ProposalAppendix%201_EvBase_FV.pdf
89 Transforming Services, Changing Lives. Case for Change
90 SUS data 2024/15
and have more complex conditions than they do now. This means that we need to work very differently to use our scare resources in the most effective way to help people stay well, out of hospital and save their lives in an emergency.

The paediatric emergency care system is facing similar challenges; we have a growing young population and limited numbers of specialist staff meaning emergency care provision is variable. There are insufficient paediatric consultants to cover emergency departments at all sites, and consequently there is a reliance on the paediatric acute team to support emergency departments, diverting clinical care away from inpatients. With an estimated 16,000 more children across Newham, Tower Hamlets, Redbridge and Waltham Forest by 2019 there is a clear case for change.

6.2 Model of care

In order to deliver safe, sustainable and high quality services for local people, we must radically change the way the emergency care system works:

- Three strong local hospitals are needed (Newham University Hospital, Royal London Hospital and Whipps Cross University Hospital), each with an urgent care centre and emergency department. Each of these sites need to be able to provide the vast majority of care for the local population. These will need to work together as a network\(^{91}\) in order to deliver the highest quality care locally, wherever possible, whilst making best use of specialist resources when we know this saves lives and aids recovery\(^{92}\).

- The front end urgent care centre offered at local emergency departments must be improved to allow these departments to be used for emergencies only. Please see the part 3, section 2 on plans for an integrated urgent care model for further details.

- We need to embed ambulatory care\(^{93}\), models at each site so that hospitals and community services can treat people who do not need 24-hour nursing care outside of a hospital bed. This will include access to specialist input on the same day, to avoid unnecessary admission to a hospital bed, whilst ensuring best practice treatment and patient experience.

- Hospitals must change how they operate. They must change from an outdated model where admission to wards is often required for the patient to gain access to expert staff and equipment, to become local hubs of acute clinical expertise, organised in a way to meet the needs of local people quickly and conveniently. Hospital specialists will need to work closely with each emergency department to treat people in ways that reduce the need for people to be admitted to, or spend unnecessary time in, hospital beds. We need to fully engage with GPs, primary care and community services to establish direct referral pathways and define how follow up treatment is managed.

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\(^{91}\) This is a finding of the Keogh review [https://www.england.nhs.uk/2013/11/13/keogh-urgent-emergency/](https://www.england.nhs.uk/2013/11/13/keogh-urgent-emergency/)


\(^{93}\) Ambulatory care is emergency medical care (diagnosis and treatment) delivered to emergency patients who visit hospital and depart on the same day (with possible on-going follow up).
Establishing acute care hubs at each hospital site

The Future Hospital Commission\(^\text{94}\) was established in 2014 by the Royal College of Physicians with the aim of putting patients' needs first and redesigning hospital services to meet these needs. One of their recommendations was the concept of 'acute care hubs'.

These acute care hubs bring together senior clinical expertise from medical and surgical specialties to focus on the initial assessment and stabilisation of acutely ill patients with a view to completing treatment and recovery within 48 hours through a multi-disciplinary team approach.

What this means for our different sites in terms of emergency provision can be seen below:

**Newham and Whipps Cross could have:**

**The Royal London could have:**

The acute care hub consists of the following teams and functions:

- Emergency department
- Paediatric emergency department
- Ambulatory care unit with hot clinic facilities

\(^{94}\) Royal College of Physicians: Future Hospitals Commission. 2014 [www.rcplondon.ac.uk/projects/future-hospital-commission](http://www.rcplondon.ac.uk/projects/future-hospital-commission)
• Paediatric short stay unit (performing the functions of a clinical decision, assessment, and delivering paediatric ambulatory care).

• Short stay unit

Through co-location of the acute medical team alongside emergency care colleagues, the acute care hub creates a clinically-led, collaborative focal point which unites these previously separate areas of clinical care. The hub acts as a central nervous system of the hospital, focusing on emergency and general medicine.

Our proposed changes aim to achieve:

• Emergency consultant cover (minimum of 14 hours a day, seven days a week, working towards 16 hours a day within the next three years).

• Rapid assessment and triage by senior decision maker in the emergency departments.

• Paediatric consultant cover (Between 10:00 and 22:00, seven days a week).

• Adherence to the new pan-London mental health crisis standard (see dedicated section on crisis mental health later in this chapter).

• 24/7 ability to assess, safely stabilise and transfer patients via agreed specialist pathways.

• 24/7 timely access to high quality diagnostics (imaging and laboratory, endoscopy, echocardiography and physiological testing)\(^95\).

**Seeing the right specialist as early as possible in the patient journey**

The acute care hub model focuses specialist clinicians towards the ‘front door’ of the hospital. Seeing the right specialist as early as possible improves patient care and recovery and reduces length of stay.

Patients will be assessed and receive preliminary diagnosis by a senior doctor, and should see a specialist in their condition as soon as possible. In some cases this might mean seeing multiple specialists for some patients. However, the specialists should be brought to review the patient in the short stay or ambulatory facility rather than the patient moving around the hospital. This will mean patients will be treated in the most appropriate care setting for their needs and will only be admitted to specialist wards when they really need to be.

In order to implement this model, consultant physicians from a wide range of specialities will support colleagues in the emergency care team and will spend sessions providing direct clinical care and specialist opinion in the hub. This will mean spending more time supporting ‘generalists’ so they are able to provide rapid consultation without the need for patients to spend any unnecessary time in the hospital. This will in effect help to increase the skill mix of staff and capability of the workforce in the diagnosis and management of acute, emergency patients.

The acute care hub will bring together the following services within the hospital:

• Emergency department

\(^{95}\) Royal College of Physicians: *Future Hospitals Commission*. 2014
[https://www.rcplondon.ac.uk/projects/future-hospital-commission](https://www.rcplondon.ac.uk/projects/future-hospital-commission)
• Consultant-led general medical ambulatory care service including rapid access to outpatient and clinic services for specialist services – known as hot clinics – where access can be granted on the same day.

• Extended outpatient antimicrobial therapy services.

• A recovery-focused short stay unit for admissions under 48 hours that provides a central area for coordination of support services.

• Handover, transfer and care package services.

This model is aligned across paediatric and adult services with an equivalent offer and purpose.

The beneficial role that ambulatory care will play

Ambulatory care is emergency medical care (diagnosis and treatment) delivered to emergency patients who visit hospital and depart on the same day (with possible on-going follow up). Focusing on ambulatory care as the primary approach to medical clinical care means reducing the treatment provided in the traditional hospital bed base.

Clinicians have told us that up to 15% of the non-elective patients that are currently admitted could be treated in ambulatory care units and we should aim to make ambulatory care the default for patients in the future.

This model would reduce the bed occupancy of specialist wards and protect capacity for the admission of complex patients with severe or acute levels of need.

Currently each site operates a different model of ambulatory care – and this is down to differences in estates and local clinical models. However, in order to deliver the full benefits of this new model of care it must be systematic and standardised. In order to do this we need to provide dedicated, fully resourced ambulatory care units at each site. The investment required for these is detailed later in this section.

Evidence from local pilots and best practice has also shown the following impacts:

• Introduction of ambulatory care avoided 90% of admissions with under 1 day length of stay\textsuperscript{96}

• Ambulatory care can be used to support an earlier discharge for patients otherwise ready to go home

• Delivering care in ambulatory care model can improve emergency departments performance\textsuperscript{97}

• When asked about the care they received through ambulatory care models, patients provided extremely positive responses (see below).

\textsuperscript{96} Presentation: Stepping into the Future, Phase 2 at Newham, June 2015

\textsuperscript{97} Running a Bigger, Better Ambulatory Care Unit, Whipps Cross Hospital pilot, May 2015
Our vision in action:

The way we currently work means treatment frequently involves hospital admission when a hospital bed isn’t always the best place for care. Each of our hospitals run some ambulatory care – but we aren’t doing enough of it. We want to make sure no patient ends up staying in hospital when they could be safe and comfortable at home. This is better for their recovery and the feedback we have had has been great.

Sarah Frankton, consultant in general medicine, Whipps Cross Hospital

Hot clinics

Hot clinics provide rapid access to medical specialist opinion. They are crucial in delivering effective care through this new model as they allow patients rapid access specialist treatment so they can go home safely and then return for treatment or assessment on subsequent days if needed.

This way of working is not new, but does not happen systematically across Barts Health. In order to deliver this model we need to transform outpatient services (see part 3, section 8 on pathways) as well as put in place effective tariff and payment mechanisms.

Introducing hot clinics across our hospital sites will also enable us to support more people to recover safely at home. We will do this by delivering a range of informal outpatient services for a range of conditions requiring treatment with intravenous or intensive courses of antibiotics and anticoagulants (OPAT services). Knowledge gained from recent provision of this type of service at the Royal London (where OPAT is integrated with community and primary care services in Tower Hamlets) suggests that 30% of the patients currently on these treatments in hospital could recover at home safely and return to the hospital for appropriate treatment the next day. Looking further into the future, this model of care has the potential to be introduced across range of conditions currently requiring inpatient treatment.

Recovery focused care

Short stay units focus on accommodating patients for up to 48 hours. The units will need rapid and seven-day access to relevant diagnostic services including rapid access to endoscopy, echocardiography and mental health screening and testing. It will fall under the

Patient experience average response scores from Whipps Cross ambulatory care pilot 2015 (1-5 range)
care of acute medicine and make use of short stay and rapid treatment pathways with a focus on recovery.

Local pilots (echoing national best practice guidance) demonstrate that the use of focused recovery units in combination with ambulatory care, facilitate an earlier discharge from hospital for up to 75% of patients referred from a hospital ward98.

Support services, such as social care and pharmacy, that are essential to the multi-disciplinary team (MDT) environment will be based within this unit. The concentration of these staff groups, which focus on recovery and re-ablement, in the short stay unit will ensure patients are discharged as soon as possible, in the knowledge they will be stable and safe in their own home.

The new short stay unit will ensure that all patients continue to receive prompt specialist care and support aligned to their needs, maximising alternatives to a longer hospital admission, and improving safety, outcomes and patient experience.

To enable this recovery focussed unit to operate effectively, health and social care services in the community need to be organised and integrated with the teams staffing the short stay unit. This will enable patients to be rapidly discharged on the day they no longer require an acute hospital bed rather than waiting for an assessment and care package to be put in place. The co-location of health and social care staff in the short stay unit will provide the opportunity for MDT team meetings with all professionals able to review each patient’s care plan and their arrangements for recovery and leaving hospital.

Potential changes to paediatric services

In order to deliver better quality paediatric services we need to adopt a model that focuses on ambulatory care at each hospital site. This mirrors in principles the adult model of acute care set out above. This will bring the paediatric acute physician closer to the front door of emergency departments, and mean only admitting a patient to a traditional ward if necessary.

The creation of paediatric assessment units (PAU) at hospital sites will allow the effective delivery of ambulatory care for children during the day with consultant oversight, without

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98 Stepping into the Future, Newham Ambulatory Care Pilot Review, June 2015
needing to admit the patient for an overnight stay. The PAU would work alongside the functions of a clinical decision unit and mean that fewer patients are admitted to a ward and ward staff have more time to care for the sickest children. It also means that general paediatric consultants are better able to support the emergency departments in caring for any children. The model aims to deliver paediatric consultant cover in emergency departments between 10:00 and 22:00 hrs and appropriate nursing cover 24/7.

In order to deliver this new model of care there will need to be investments in appropriate nursing and medical workforce, as well as changes to the way that consultants currently work across and within hospital sites. This will need to include changing job plans to ensure adequate senior clinical oversight at each site.

Proposed model of paediatric hospital care and interaction with other teams

As outlined in the Facing the Future Together99 report, the success in improving health care and outcomes for children and young people with acute illness relies on teams inside and outside of the hospital working together. In the case of paediatrics there is a need to ensure appropriate support for GPs and community staff. This is detailed in the model above in the role of the ‘locality paediatrician’. This work is being taken forward in conversations with boroughs.

As part of this model, there would also need to be improved out-of-hours support and transfer arrangements across sites which need to be developed in partnership with London Ambulance Service NHS Trust.

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Mental health crisis

Creating acute care hubs, as set out in this chapter, aims to make sure our hospitals provide safe and effective care for people experiencing a mental health crisis. They will include:

- a dedicated area for mental health assessments which reflects the needs of people experiencing a mental health crisis and is in accordance with Royal College of Psychologists standards
- access to on-site liaison psychiatry services 24 hours a day, seven days a week
- liaison psychiatry services to see service users within one hour of emergency department referral
- arrangements in place to ensure Mental Health Act assessments take place promptly and reflect the needs of the individual concerned
- access to all the information required to make decisions regarding crisis management including self-referral.

Similarly for children we will aim to provide:

- single call access for children and adolescent mental health (CAMHS) (or adult mental health services with paediatric competencies for children over 12 years old) referrals to be available 24 hours a day, seven days a week with a maximum response time of 30 minutes
- access for staff to telephone consultations and an on-site response from a dedicated pool of CAMHS professionals known to the local hospital during, and out-of-hours.

N.B. Full costing and benefits of the mental health changes have not yet been included in the financial modelling. Further work needs to take place to understand if there needs to be any change in investment, above what is currently being planned locally, in order to deliver these changes.

How we will deliver acute care hubs at each site

In order to maximise the benefits of this clinical model we are proposing to put in place a dedicated ambulatory care unit at each site. This will need to be accompanied by changes to existing facilities to enable the other elements of the acute care hubs model to be delivered e.g. hot clinics and dedicated short stay units.

There is a need to focus on embedding the functions of each element of the model of care as each site is set up slightly differently. A focus on pathways will be key to ensuring real change, not simply ‘relabelling’ of units.

Newham, Whipps Cross and the Royal London Hospital each has in place some elements of the acute care hub model, however, there is a need for capital investment, as well as changes to working practices in order to realise the benefits and establish this new way of working as standard clinical practice across Barts Health. The grid below summarises the key changes required at each site to deliver this model.
<table>
<thead>
<tr>
<th>Time frame</th>
<th>Royal London Hospital</th>
<th>Whipps Cross University Hospital</th>
<th>Newham Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short term / immediate</td>
<td>• Move to co-locate existing services with emergency department on ground floor (recruitment of additional acute medical workforce complete)</td>
<td>• Extended hours of operation for existing unit – moving to an 8am to 8pm model, seven days a week</td>
<td>• Addition of new ambulatory care pathways to current clinical decision unit/short stay unit treatment list. • Additional recruitment of acute medical workforce</td>
</tr>
<tr>
<td>actions</td>
<td></td>
<td>• Additional recruitment of acute medical workforce</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Creation of PASSU</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium term</td>
<td>• Expansion of services and organisational development and workforce changes</td>
<td>• Temporary estates changes to provide additional seated treatment areas and changes to workforce</td>
<td>• Temporary estates changes to provide additional seated treatment areas and changes to workforce</td>
</tr>
<tr>
<td></td>
<td>• Roll out of Hot Clinics across specialties</td>
<td>• Boost to OPAT services to be consultant-led</td>
<td>• Boost to OPAT services to consultant led</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Roll out of Hot Clinics across specialties</td>
<td>• Rainbow ward opens – allowing for PASSU working</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Roll out of Hot Clinics across specialties</td>
</tr>
<tr>
<td>Long term</td>
<td>• Consolidation of model and addition of exception pathways to enable 'ambulatory care as default' for treatment</td>
<td>• New capital build to provide purpose built centre</td>
<td>• New capital build to refurb mothballed ward for ambulatory care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The key programme milestones are further outlined in the next steps section.

**Workforce of the future**

Acute care hubs aim to maximise the use of workforce skills and expertise. Each element of the new model will require changes to the way staff work.

We know that there are national shortages of consultants in emergency medicine; theatre nurses; CT3 trainees and ST4 to ST7 trainees in emergency medicine; non-consultant, non-training medical staff in emergency medicine (including specialty doctors working in A&E); and paramedics. In order to address this, significant investment has been made across London into increasing emergency medicine training and developing new roles. It is projected that within three years we shall move from under-recruitment to having the right number of trainees to match existing posts[^100].

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Given this, in order to deliver the new models of care outlined in this section the emphasis over the next few years needs to be on developing new ways of working across emergency and acute medicine rather than solely recruitment.

The future workforce must meet the needs of patients needing input from across the health and social care system. This will include the expertise to manage frail older patients with dementia, and lead and coordinate the ‘whole care’ of patients in hospital and the community. Across the overall physician workforce there will need to be the right skill mix to deliver appropriate:

- specialisation of care (e.g. access to sufficient specialty expertise to deliver diagnosis, treatment and care appropriate to the specific hospital setting)
- intensity of care (e.g. access to sufficient expertise to manage, coordinate and deliver enhanced care to patients with critical illness)
- coordination of care (e.g. access to sufficient expertise to coordinate care for patients with complex and multiple comorbidities).

Most physicians, whatever their specialty, will possess and deploy a combination of these skills in their roles. However, structures and roles will need to be designed to support and enhance the delivery of high-quality emergency care, and embed strong clinical leadership.

There will also need to be changes to the way community staff work with on-ward recovery\textsuperscript{101}, nursing, occupational therapy and physiotherapy, together with dementia specialty nursing, local authority social services, ambulance liaison and pharmacy/enhanced prescribing. Some of these resources may present a challenge, given skills shortages within professions both national and locally.

The following organisational development work programmes have been identified, and costed, these are detailed in the section on investment costs.

- re-training of staff to perform new roles in acute care hubs including strengthening the MDT working approach across medical specialties.
- support for integration of community and social support services.

There are also overarching issues that need to be addressed to attract staff to East London as part of an overall recruitment/retention and organisational development (OD) strategy, which include:

- the high and rising cost of living in London
- transport difficulties (particularly for community-based workers who need to use personal rather than public transport to do their work)
- availability of low cost/key worker accommodation etc.

The high turnover in specific staff groups in emergency services and also London Ambulance Service, indicates a need to investigate at a local level and develop an appropriate OD strategy designed to improve retention rates.

\textbf{This [acute care hub] has major implications for the clinical practice of physicians, the training of future generations of physicians, for research and – most importantly of all – for}\footnote{\textsuperscript{101} Nurses that focus on the recover and re-ablement of patients but work within a hospital or ward setting}
patients. Its implementation will be a challenge for us all – but implement it we must. Our present and future patients will expect – indeed demand – no less.

Sir Michael Rawlins, Chair, Future Hospital Commission

6.3 Other significant change initiatives not costed here

Below are significant other schemes related to this area of care/change that might in the future need to be fully costed and assessed for level of impact.

- Embedded standards of care for frail elderly patients, focusing on mental health needs, including dementia; working with community and social care partners to improve timely supported discharge given the disproportionately high lengths of stay observed within this patient group.

- Review capacity of ‘step-down’ rehabilitation beds in the community, including the potential for enhanced contracts with nursing and care homes. An enhanced contract would aim to enhance quality of health care for nursing home residents in association with pharmacy and nursing staff, offering alternatives to admissions to acute hospitals. 103

6.4 Engagement

The focus of engagement has been on developing and understanding the potential impacts of this clinical model, the benefits for patients and aligning this with current performance and operational improvement initiatives as well as starting to understand the potential impact on future patient flows. The following stakeholders or stakeholder groups have been engaged or have helped to shape these proposals:

- Transforming Services Together Clinical Reference Board
- East London Clinical Strategy Group
- Barts Health Clinical Academic Strategy Board
- CCG governing body development sessions board meetings
- Healthwatch Waltham Forest (involved in Health Foundation bid for ambulatory care at Whipps Cross Hospital)
- Barts Health TST Strategy Group
- TST Children and Young People Working Group, Acute Medicine Working Group and Emergency Care Working Group
- CCG governing bodies
- Programme director representation at North East London Advisory Group and NEL urgent & emergency care network (covers all seven north east London CCG areas)
- Regular attendance at TST urgent care steering group, local urgent care working groups, East London operational resilience group

103 Example of a local enhanced service provision for patients in nursing and residential homes www.hscbusiness.hscni.net/pdf/LES_Nursing_Homes_Policy.pdf
6.5 Outcomes the change will achieve

The details below show the high level impact of implementing the acute care hub model:

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients treated through ambulatory care as a percentage of non-elective hospital admissions</td>
<td>15%</td>
</tr>
</tbody>
</table>

There would also be an expected Impact on improvement in four hour target performance for the emergency department (95% target). Pilots and evidence suggests this could be up to a 5% improvement.

The next steps will be to understand the shifts in more detail. Below are some examples for how this might break down:

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP referrals for emergency admission can be treated and discharged same day</td>
<td>50%&lt;sup&gt;104&lt;/sup&gt;</td>
</tr>
<tr>
<td>Reduction in non-elective admissions of less than 24 hours</td>
<td>80%&lt;sup&gt;105&lt;/sup&gt;</td>
</tr>
<tr>
<td>Reduction in non-elective admissions of between 24-48 hours</td>
<td>10%</td>
</tr>
<tr>
<td>Reduction in non-elective average length of stay</td>
<td>0.1 day</td>
</tr>
<tr>
<td>Reduction in treatment costs for patients requiring antimicrobial therapy / infectious disease / anti-coagulation treatment</td>
<td>15%</td>
</tr>
</tbody>
</table>

Agreement on programme outcomes will be agreed as a next step with clinical leads at Barts Health representing the emergency care and acute medicine network and as part of implementation planning.

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<sup>104</sup> Nottingham University Health Trust, Health and Social Care Journal, Thompson and Connolly May 2014 [www.hsj.co.uk/home/innovation-and-efficiency/all-in-a-days-work-the-drive-for-better-ambulatory-care/5070218.article#.VfLbjmFMuQ](www.hsj.co.uk/home/innovation-and-efficiency/all-in-a-days-work-the-drive-for-better-ambulatory-care/5070218.article#.VfLbjmFMuQ)


<sup>106</sup> Whipps Cross and Newham Hospital Ambulatory Care pilot data, TST programme May and June 2015
6.6 Investment costs

In order to implement acute care hubs as described in this chapter the following investments are required.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital costs inc. capital revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>£2.68m</td>
<td>£2.68m</td>
<td>£2.68m</td>
<td>£2.68m</td>
<td>£2.68m</td>
<td>£10.72m</td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Including project implementation costs (e.g. project management, procurement etc)</td>
<td>£5.6m</td>
<td>£5.8m</td>
<td>£5.8m</td>
<td>£5.8m</td>
<td>£5.6m</td>
<td>£28.8m</td>
</tr>
<tr>
<td>OD costs</td>
<td>£0.21m</td>
<td>£0.16m</td>
<td></td>
<td></td>
<td></td>
<td>£0.37m</td>
</tr>
</tbody>
</table>

6.7 Impact on activity and revenue

The acute care hub model is predicated on senior clinical decision-making and specialist review and treatment delivered as early as possible in each patient journey. The revised service remains focused on the patients that report to the emergency department either by ambulance, walk in or by referral from a GP or other appropriate referring practitioner.

Treating people without admitting them to a hospital bed

The acute care hub model reduces the number of non-elective hospital admissions. To meet the aim of reducing the non-elective admissions by 15% overall, all aspects of the model described in the chapter must be in place. Phasing of the different elements is described at a high level in part 3, section 6.2
The charts above show the impact of the acute care hub and OPAT schemes on non-elective, emergency activity at Barts Health NHS Trust. (For all CCGs, including specialised commissioning)

- It is anticipated that in 2020/21 there will be an additional 6708 non-elective admissions due to baseline adjustments, including an estimate of the impact of the potential KGH closure.
- It is also anticipated that there will be an additional 10,228 non-elective admissions due to growth.
- The Acute Care Hub and OPAT schemes are expected to reduce activity by 23,737 admissions in 2020/21.

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed reduction (cumulative)</td>
<td>0</td>
<td>-118</td>
<td>-142</td>
<td>-145</td>
<td>-147</td>
<td>-150</td>
</tr>
<tr>
<td>Bed reduction (yearly)</td>
<td>0</td>
<td>-118</td>
<td>-24</td>
<td>-2</td>
<td>-3</td>
<td>-2</td>
</tr>
</tbody>
</table>

Source: TST Activity/Finance Model based on SUS data provided by NEL CSU
Trusts included: Barts Health NHS Trust: All Sites (excludes beds in Midwife led units)
CCGs included: All CCGs commissioning activity from Bart’s Health NHS Trust
Specialised Commissioned Activity included: Yes
PODs included: Non-Elective Activity (excluding non-elective non-emergency) – Codes incl: NEL, NELSD, NELST
Baseline Adjustments: Heart hospital move, London Chest closure, KGH closure
Further work is required to understand what this capacity could be used for in the future but could include:

- Support delivery of elective activity.
- Change of use.

The utilisation of this capacity should be developed jointly by the provider and relevant CCG.

**Re-provision of care**

Activity as a result of admissions avoided will be re-provided through ambulatory care units at each site as part of the acute care hub model. This includes follow up patient contacts provided through hot clinics (assumption of 1:1 ratio has been used based on local pilots\(^{107}\)).

The activity described in the tables below has been used to develop the workforce requirement. Additional activity will also be provided to ward patients for support in facilitating earlier discharge.

**Patient contacts per year in ambulatory care**

<table>
<thead>
<tr>
<th>Site</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London</td>
<td>18,664</td>
<td>23,233</td>
<td>23,760</td>
<td>24,323</td>
<td>24,796</td>
</tr>
<tr>
<td>Newham hospital</td>
<td>16,655</td>
<td>21,469</td>
<td>21,775</td>
<td>22,123</td>
<td>22,422</td>
</tr>
<tr>
<td>Whipps Cross hospital</td>
<td>19,946</td>
<td>24,892</td>
<td>25,125</td>
<td>25,372</td>
<td>25,648</td>
</tr>
<tr>
<td><strong>Barts Health Total</strong></td>
<td><strong>55,265</strong></td>
<td><strong>69,594</strong></td>
<td><strong>70,660</strong></td>
<td><strong>71,817</strong></td>
<td><strong>72,866</strong></td>
</tr>
</tbody>
</table>

**Patient contacts per day in ambulatory care (average)**

<table>
<thead>
<tr>
<th>Site</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Royal London</td>
<td>51</td>
<td>64</td>
<td>65</td>
<td>67</td>
<td>68</td>
</tr>
<tr>
<td>Newham hospital</td>
<td>46</td>
<td>59</td>
<td>60</td>
<td>61</td>
<td>61</td>
</tr>
<tr>
<td>Whipps Cross hospital</td>
<td>55</td>
<td>68</td>
<td>69</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td><strong>Barts Health Total</strong></td>
<td><strong>151</strong></td>
<td><strong>191</strong></td>
<td><strong>194</strong></td>
<td><strong>197</strong></td>
<td><strong>200</strong></td>
</tr>
</tbody>
</table>

The large number of patient contacts per day demonstrates the need for investment in workforce and estates to enable appropriate delivery of the new service model as described in the investment costs section.

The outputs projected are indicative figures associated with both activity and costs based on current documented assumptions. Further financial management work is required to analyse the impact of this change to the service model moving forward.

\(^{107}\) Stepping into the Future, Newham Ambulatory Care Pilot review, June 2015 and Whipps Cross extended ambulatory care pilot review, June 2015
Financial impact and sensitivity analysis

After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £22.6m to £35.7m over a five year period dependent on the extent and timescale in which acute care hubs are established at each site.

6.8 Commercial considerations and transitional support required

The key commercial considerations in taking this work forward are:

- Tendering issues around any new build or major works e.g. proposed ambulatory care units.
- Managing the released capacity in a sustainable way.
- Agreeing appropriate tariff arrangements to incentivise and ensure new models of ambulatory care are embedded and sustainable.

During the period of implementation and transition, support should be provided to facilitate the process and ensure that the system has adequate resource to complete the necessary changes without diminishing quality of service delivery. Consideration should be made for potential additional clinical support staff and ‘double running’ of some nursing and junior doctor roles to sustain quality of service.

6.9 Delivery risks

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk likelihood</th>
<th>Risk impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Ability to implement and run existing services concurrently</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Invest in project support and possible double running of clinical teams</td>
</tr>
<tr>
<td>2 Insufficient stakeholder engagement to deliver large scale change and secure system-wide buy in</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Re-focus identification of key stakeholders to engage</td>
</tr>
<tr>
<td>3 Need to manage interdependencies across other workstreams i.e. primary care, integrated care, end of life care, community services and discharge.</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Managed through ongoing links between project managers</td>
</tr>
<tr>
<td>4</td>
<td>Lack of emergency and acute general medical workforce</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>5</td>
<td>Potentially lack of capital investment available</td>
<td>3</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>

### 6.10 Next steps

Development of the ambulatory care model across three of the acute provider sites has begun in earnest, in part due to the success of site specific trials and the desire to put in place a more sustainable model of care ahead of winter 2015/16. A phased approach will be applied to further implementation to ensure clarity of outcomes, clinical models and investments required:

<table>
<thead>
<tr>
<th>Phase One</th>
<th>Outline</th>
<th>Indicative timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical validation of new model</td>
<td>• Work with clinical leads to test clinical interdependencies and future model and set clear outcomes across sites</td>
<td>January 2016</td>
</tr>
<tr>
<td>Public engagement</td>
<td>• Work with TST PPRG and Healthwatch to test and refine proposals with patient input</td>
<td>January 2016</td>
</tr>
<tr>
<td>Emergency surgery network</td>
<td>• Work to formalise emergency and acute medicine network across Barts Health sites. <em>For details see chapter on surgical changes</em></td>
<td>January 2016 (ongoing)</td>
</tr>
<tr>
<td>Business case for acute care hub at each site</td>
<td>• A full business case will be required for full workforce and capital investment of new model</td>
<td>March 2016</td>
</tr>
<tr>
<td>Implementation</td>
<td>• Phase one of the implementation allows each provider an opportunity to invest and crystallise its current service model in line with the</td>
<td>March 2016</td>
</tr>
</tbody>
</table>
developing strategy supported by the TST programme

<table>
<thead>
<tr>
<th>Phase Two</th>
<th>Outline</th>
<th>Indicative timescale</th>
</tr>
</thead>
</table>
| Workforce and OD | • Workforce investment including organisational development initiatives  
• Understand the impact on the nursing and support services workforce and the process of role evaluation and redeployment to meet new service needs  
• Implementation of best practice methodology  
• Agreement on job planning changes to support service delivery  
_A workforce consultation will need to accompany this work and should be completed before a final recruitment drive occurs for nursing establishment (if required)._ | April 2016 |
| Primary care clinical engagement | • Engagement programme with GPs, other primary care referral sources and community services to advise and educate on the new model and define how it will interact with (and determine the potential impact on) services outside of hospital as follow up care will also be required | April 2016 |
| Capital works | • Begin build of agreed estate location for each acute care hub | September 2016 (Ongoing) |

<table>
<thead>
<tr>
<th>Phase Three</th>
<th>Outline</th>
<th>Indicative timescale</th>
</tr>
</thead>
</table>
| Workforce and OD | • Completion of organisational development initiatives  
• Completed workforce investment  
• Defined and completed job planning and job roles in each team | April 2017 |
| Referrer engagement | • Engagement programme with GPs, other primary care referral sources and community services to advise and educate on the new model and define how it will interact with (and determine the potential impact on) services outside of hospital as follow up care will also be required. | April 2017 |
| Capital works | • Build completion  
• Acute care hub model fully operational at each site | September 2017 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Service relocation</td>
<td>• Physical co-location of teams to take place into new facility</td>
<td>January 2018</td>
</tr>
</tbody>
</table>
7: Increase the proportion of natural births

7.1 The case for change

The Maternity and Newborn Care Clinical Working Group report for the Transforming Services Changing Lives (TSCL) Case for Change\(^{108}\) highlighted a range of issues about the quality of care that women and their families in north east London receive through pregnancy, birth and the postnatal period.

Central to the report was the observation that women in the area consistently reported having some of the worst experiences of care in London\(^ {109}\). Care was at times perceived to be unsupportive, fragmented, and provided in places that were hard to reach. In addition, across north east London, the standards of provision and approaches to maternity were seen to vary between organisations, resulting in inequity of service and variable outcomes.

However, within this review there was also recognition that maternity services were struggling with the challenges of a population whose health complexity was increasing, of rising birth rates, staffing levels below recognised standards, and estate that did not meet the needs of users.

The scale of those challenges cannot be underestimated. Over the next ten years it is predicted that there will be another 5,000 births per year across north east London\(^ {110}\). The focus of this increase is expected to be around Tower Hamlets and Newham with increases in births of 32% and 22% respectively.

Meeting this future demand through the current model of care is not feasible. Both the Royal London and Newham hospitals’ obstetric-led maternity services are already working at capacity and the Whipps Cross estate is in need of significant redevelopment to meet modern standards in line with the other sites.

Place of birth has been identified as a hugely important issue in improving quality and managing demand, with compelling evidence about the impact it can have on the health of women and babies\(^ {111}\).

The current organisation of care is orientated around the majority of women giving birth in obstetric-led labour wards. Described by clinicians as the ‘default’ place of birth, 86% of women across Barts Health gave birth in a labour ward in 2013/14, although in this figure there is significant variation across the three sites.

But national evidence\(^ {112}\) has led to the conclusion that women having a straightforward pregnancy should be advised to give birth in places other than obstetric-led settings. Obstetric-led settings place women at higher risk of unnecessary intervention such as caesarean and operative births compared with planned midwife-led births in a birth centre or

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\(^{109}\) Care Quality Commission Maternity Services Survey. 2013 [www.cqc.org.uk/content/maternity-services-survey-2013](http://www.cqc.org.uk/content/maternity-services-survey-2013)


\(^{112}\) Ibid
There is also evidence emerging that women with some risk factors (e.g., previous caesarean section) who traditionally would be automatically advised to give birth in a labour ward, may benefit from having their baby at home or in a birth centre. Out-of-Obstetric Unit (OoOU) births offer many benefits to all involved in maternity care provision. Women are highly satisfied with births in such settings, experience less interventions, and are more likely to breastfeed their babies. These types of birth are also more efficient, less resource intensive way of providing care with significantly cheaper costs per birth and are popular with midwives. An additional benefit is that the obstetric unit can focus care on those with the greatest need.

Over many years women have reported their choices being mixed or limited both nationally and locally, despite government commitment that women should be offered choice of place of birth (but recognising that this is something which is not always experienced by women).

In recent years Barts Health NHS Trust and other East London maternity service providers have recognised the need for change and moved towards providing more out-of-obstetric unit care. One particular area of focus has been around continuity of midwifery care, a concept that in maternity has been part of government policy in various forms for over 20 years and which itself has the potential to meet women’s needs; decrease intervention rates; improve satisfaction for women; and decrease the rates of pre-term birth, instrumental births and foetal losses before 24 weeks, while increasing rates of normal births and breastfeeding. There is also a statistically significant trend to such models being more cost effective to provide. Our strategy recognises the importance of the desire of providers to improve care for women and seeks to work together to create a far-reaching strategy for the benefit of women and families in this area.

7.2 Model of care

At its core, the proposed care model focuses on ensuring that service provision is orientated around providing a good experience of care for women, supporting them through their pregnancy, birth and post-birth journey. Several key principles have emerged that support this aim and are described below.

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114 The Birthplace in England national prospective cohort study: further analyses to enhance policy and service delivery decision-making for planned place of birth. NIHR. Hollowell J. et al. 2015 http://www.nets.nihr.ac.uk/projects/hsdr/10100843


Increasing the number of births outside of the obstetric unit (OoOU)

In view of the known benefits of birth outside the obstetric unit (OU) this approach is a key strategy focus, with the aim being to encourage a shift 36% of births away to non-OU settings. This work is already in progress with the variation across site seen in the table below. Development of estates is crucial for the Royal London and Whipps Cross sites to fulfil these ambitions. The Royal London is planning to open an alongside midwifery-led unit in spring 2016. For Whipps Cross, widespread improvements are urgently required, including basic provision such as individual bathrooms for women in labour.

Increasing access to birthing centres will also be reliant on ensuring that local guidelines and protocols do not unnecessarily excluding women. For example, at Whipps Cross vigorous review and challenge of the outpatient induction of labour pathway enabled more women to access the birth centre, and also supported a significant reduction in the caesarean section rate. Sites will be reviewing this improvement work in the coming months and undertaking staff training needs analysis to support its implementation.

Continuity of midwifery care

This strategy aims to ensure that all women have continuity of care from a named midwife throughout their pregnancy, starting from their first appointment with the service. Barts Health’s three maternity sites have each been working to identify models of midwifery provision to support continuity of care across the whole pregnancy and birth journey. A
A review of this work and aspects of the various types of service provision at each site can be seen in the table below.

### Variation in current models of community and continuity of midwifery care

<table>
<thead>
<tr>
<th>Criteria used for comparison</th>
<th>Newham University Hospital</th>
<th>The Royal London Hospital</th>
<th>Whipps Cross University Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there community midwifery team provision?</td>
<td>◆</td>
<td>◆</td>
<td>◆</td>
</tr>
<tr>
<td>Can all women be looked after by a community team?</td>
<td>◆</td>
<td>◆</td>
<td>◆</td>
</tr>
<tr>
<td>Does the current model of care provide continuity of midwife across pregnancy, birth and postnatal period?</td>
<td>◆ Available to very small group only</td>
<td>◆ Available to very small group only</td>
<td>◆</td>
</tr>
<tr>
<td>Does continuity start from booking?</td>
<td>◆</td>
<td>◆</td>
<td>◆</td>
</tr>
<tr>
<td>Can all women access all options of out-of-obstetric unit birth at this site</td>
<td>◆</td>
<td>◆</td>
<td>◆</td>
</tr>
<tr>
<td>Current numbers of women giving birth outside of the obstetric unit</td>
<td>21%</td>
<td>13%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Key:** ◆ Available to all women ◆ Availability limited ◆ Not available

Currently the models of maternity care being developed are teams of community midwives providing care for women throughout pregnancy and the postnatal period. By being located in the community, care is delivered closer to home. Some small areas have also started offering continuity of care during labour, but these have been limited; for example women who live in one postcode, have a particular planned place of birth, or a particular risk profile. There is therefore a need for significant expansion to meet our aims.

Moving to midwifery-led models of care orientated towards providing women with continuity of care requires significant organisational development amongst providers and different sites. Services which have experienced this describe the need to support midwives in developing their skill sets to support independent working\(^\text{117}\). In addition, to effectively monitor activity and quality, and enable efficient working, a significant investment in IT will be required.

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The range of services across the three Barts Health sites suggests that each site will need to develop its own implementation plan to reach the agreed strategic aims.

7.3 Other significant change initiatives not costed here

Transitional care
Transitional care is the provision of care for babies who require more input into their care than the standard advice and guidance offered by clinicians to a normal, well baby. Typically these babies may require prophylactic antibiotics, phototherapy, or intensive feeding support or monitoring. The organisation of care for these babies is approached differently around the country but has a significant impact on maternity services. Generally these babies are cared for with their mothers on the postnatal ward\(^{118}\).

Looking after mother and baby together is good practice and is regarded as the core organising principle of care. However what has emerged in both anecdotal evidence and data sets from Barts Health is that the transitional care is contributing to increased maternal length of stay in maternity beds, when babies require prolonged treatment. The scale of the issue has yet to be defined but all three sites have expressed concern about the impact on the capacity of the unit, in terms of physical space, midwifery workforce and women’s experience.

Further work will need to be undertaken to explore the scale of this issue and potential solutions to this challenge.

Perinatal mental health
Perinatal mental health is an issue of growing concern in maternity services across the UK with increasing recognition of the long term impact on the family and growing child if left untreated. A recent national survey of services for women across the country identified much good practice in north east London. However there is continuing concern amongst clinicians that the provision of services for women with mild to moderate illness remain under developed, with lack of identification being a key issue.

The organisation of care described above will support improved relationships between women and their care providers allowing better recognition of need, communication between agencies, and support for women and their families.

7.4 Engagement

Given the inter-related nature of the north east London maternity sector and the need to provide safe maternity care across the area, engagement workshops have included invitees from the whole area, both clinical and commissioner\(^{119}\).

Meetings, briefings and other contact:
- Waltham Forest and East London and City maternity commissioners’ alliance monthly meetings. Invitees include commissioners and GP maternity leads from

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\(^{118}\) British Association of Perinatal Medicine. Categories of Care. 2011

\(^{119}\) Discussions take into account the existing models of care in each area.
Newham, Tower Hamlets, Waltham Forest and City and Hackney; GP maternity lead from Redbridge CCG; contracting representatives from NEL CSU; head of maternity commissioning for north east London (seven CCG areas)

- Regular meetings and communication with the consultant obstetric lead, heads of midwifery, midwifery leads and managerial and strategic leads at Barts Health
- Briefed ‘Incentives and Levers Working Group’ within National Maternity Review
- Email communication with ‘Model of Care Group’ within National Maternity Review
- Discussion with executive leads from all seven CCG areas, and medical directors and executive leads from provider organisations in the area, via North East London Advisory Group (NELAG)
- Email exchange with Tower Hamlets volunteer home birth advocate and service user
- Meeting held arranged with clinical lead directors for maternity across north east London CCGs to discuss impact of potential TST initiatives on primary care role
- Site-specific meetings with work stream executive and director, lead consultant, head of midwifery and consultant midwives to discuss and agree OoOU birth aspirations.

**Workshops: Five focused workshops (January to September 2015):**

1. Developing the maternity and newborn care strategy (27 February)
2. Maternity and neonatal care workshop (17 April)
3. New model for transitional care workshop (12 May)
4. Maternity and newborn care stakeholder workshop (3 June)
5. Joint TST and Barts Health workshop (5 August) on internal efficiency.

Invitees included commissioners and GP maternity leads from Newham, Tower Hamlets, Waltham Forest and Redbridge; consultant obstetricians, heads of midwifery, other midwifery leads, superintendent sonographer, neonatology clinical director, consultant gynaecologist, primary care lead from Barts Health NHS Trust; consultant obstetrician, head of midwifery, consultant neonatologist and other midwifery leads from Homerton hospital; manager for London Neonatal Network (UCLP); interim chief nurse Barking, Havering and Redbridge University Hospital; maternity quality lead for Barking, Havering and Redbridge CCGs; professor of community and family health at UEL, public health advisor, NHS England lead for neonatal care, plus a service user. Pregnant women and new mothers from Newham, Tower Hamlets, Waltham Forest, Redbridge, Barking and Dagenham, City and Hackney invited via Maternity Services Liaison Committee and Healthwatch (13 attended the workshop held on 3 June 2015).
7.5 Benefits the change will achieve

The high-level impacts of this initiative are:

1. Greater numbers of women will be supported to give birth outside the obstetric unit supporting choice and creating a more sustainable maternity system in the future.

Over the next five years, Barts Health will enable an increase the proportion of births taking place in midwife-led units from 13% to 31% and the number of homebirths from 0.6% to 5%.\(^{120}\)

<table>
<thead>
<tr>
<th>Barts Health</th>
<th>Baseline</th>
<th>Y5 2020/21</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH total births forecast</td>
<td>17301</td>
<td>18561</td>
<td>1,260</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(7.2%)</td>
</tr>
<tr>
<td>Obstetric Unit (OU)</td>
<td>14,935</td>
<td>11,879</td>
<td>3056</td>
</tr>
<tr>
<td></td>
<td>(86%)</td>
<td>(64%)</td>
<td>(24%)</td>
</tr>
<tr>
<td>Midwifery-led unit (MLU)</td>
<td>2,251</td>
<td>5754</td>
<td>3,503</td>
</tr>
<tr>
<td></td>
<td>(13%)</td>
<td>(31%)</td>
<td>(18%)</td>
</tr>
<tr>
<td>Home birth (HB)</td>
<td>111</td>
<td>928</td>
<td>817</td>
</tr>
<tr>
<td></td>
<td>(0.6%)</td>
<td>(5%)</td>
<td>(4.4%)</td>
</tr>
</tbody>
</table>

Site-specific aspirations

Throughout August, September and October 2015, each site agreed their own shift aspirations based on the Birthplace study, birthrate plus audit and the working knowledge of each site’s clinical experts.

Whipps Cross Hospital (WXH): Aim is for OU = 65%; MLU = 27%; HB = 7%  

<table>
<thead>
<tr>
<th>Births Forecast</th>
<th>Baseline</th>
<th>Y1 16/17</th>
<th>Y3 18/19</th>
<th>Y5 20/21</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OU</td>
<td>4680 (94%)</td>
<td>4125 (82%)</td>
<td>3644 (73%)</td>
<td>3301 (65%)</td>
<td>1379</td>
</tr>
<tr>
<td>MLU</td>
<td>249 (5%)</td>
<td>800 (16%)</td>
<td>1200 (24%)</td>
<td>1422 (28%)</td>
<td>1173</td>
</tr>
<tr>
<td>HB</td>
<td>50 (1%)</td>
<td>100 (2%)</td>
<td>200 (4%)</td>
<td>355 (7%)</td>
<td>305</td>
</tr>
</tbody>
</table>

\(^{120}\) When determining the impact of improving the model of maternity care on shifting Intrapartum activity out of the obstetric units, the activity baseline was 2013/14 SLAM data. This was widely considered to be the most validated data available since the merger of the three trusts in 2013. In addition there was use of the site-specific aspirations in relation to the numbers of women giving birth in Obstetric Units (OU’s), midwifery-led settings such as birth centres and alongside-midwifery units, and at home. This led to Barts Health agreeing that it is clinically appropriate to aim for 64% of births to be within OUs, 31% in MLU settings and 5% in women’s homes.
Royal London Hospital: Aims is for OU = 70%; MLU = 27%; HB = 3%

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Y1 16/17</th>
<th>Y3 18/19</th>
<th>Y5 20/21</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Births</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Forecast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OU</td>
<td>5477</td>
<td>5737</td>
<td>6045</td>
<td>6328</td>
<td>851</td>
</tr>
<tr>
<td>MLU</td>
<td>4847 (88.5%)</td>
<td>4474 (78%)</td>
<td>4412 (73%)</td>
<td>4430 (70%)</td>
<td>417</td>
</tr>
<tr>
<td>HB</td>
<td>602 (11%)</td>
<td>1202 (21%)</td>
<td>1516 (25%)</td>
<td>1709 (27%)</td>
<td>1107</td>
</tr>
<tr>
<td></td>
<td>27 (0.5%)</td>
<td>57 (1%)</td>
<td>114 (2%)</td>
<td>190 (3%)</td>
<td>163</td>
</tr>
</tbody>
</table>

Newham: OU = 60%  MLU = 37% HB = 3%

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Y1 16/17</th>
<th>Y3 18/19</th>
<th>Y5 20/21</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Births</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Forecast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OU</td>
<td>6845</td>
<td>7016</td>
<td>7120</td>
<td>7155</td>
<td>310</td>
</tr>
<tr>
<td>MLU</td>
<td>5408 (79%)</td>
<td>5246 (75%)</td>
<td>4978 (70%)</td>
<td>4293 (60%)</td>
<td>1115</td>
</tr>
<tr>
<td>HB</td>
<td>1403 (20.5%)</td>
<td>1700 (24%)</td>
<td>2000 (28%)</td>
<td>2647 (37%)</td>
<td>1244</td>
</tr>
<tr>
<td></td>
<td>34 (0.5%)</td>
<td>70 (1%)</td>
<td>142 (2%)</td>
<td>215 (3%)</td>
<td>181</td>
</tr>
</tbody>
</table>

2: All women will have access to a model of midwifery care that enables them to experience continuity of care from a named midwife.

The seven core principles of this approach have been agreed by clinicians and leaders at Barts Health.

   a. Women should be at the centre of the organisation of care
   b. Women should be seen close to home/ in the community unless there is a clinical reason to bring them into hospital
   c. All women should have access to the same care pathways wherever and however they intend to give birth and whoever their carer’s are (equity of offer and experience)
   d. Women should have continuity of care from 2/3 midwives across the antenatal and postnatal period who work within a team that includes booking
   e. Women should have continuity of care from her team in the intrapartum period
   f. The default offer should be out of labour ward births unless clinical reason for planned birth in an obstetric unit.
   g. Staff should be enabled to self-manage their workload, feel valued, supported and well trained to carry out their job.

There is agreement that this approach will support equity of offer and support women’s choices, including around place of birth. In turn it is anticipated that this will improve efficient use of resources in many ways including, better throughput through decreased length of stay, decreased use of equipment and better use of staff. This should then support sustainability within the services in the face of the anticipated increased demand.

3: As more women are supported to give birth across a variety of settings, fewer medical interventions such as Caesarean section will be required.

Evidence nationally and locally from Newham strongly suggests that the intended place of birth has significant impact on her mode of birth, with midwifery-led births demonstrating
lower rates of instrumental birth and caesarean sections for women. In turn this supports quicker recovery times and reduced likelihood of complications for women, with increases in workforce and estate capacity across all settings.

Other work in progress supports this aim, such as outpatient induction of labour (IOL) protocols. (See the figure below). Supporting the sustainability of this work will be critical to prevent slippage such as seen recently in the unexplained rise in caesarean section rates across all sites.

### PROMOTING NATURAL BIRTHS AT NEWHAM HOSPITAL

- Newham have reduced caesarean section rates from 33% in 2011 to 27% in 2013. This takes them from the highest rates in East London to among the lowest in just two years.
- Normal births have been championed by midwives and obstetricians and began with a multi-professional review of benchmarked data. The DH toolkit helped identify three pathway opportunities to promote vaginal births amongst: first time mothers; women who had previously had a caesarean section birth; and women having induced births.
- Training and education and the promotion of a learning culture with monthly audits and reviews has supported consistent, evidence based care. The introduction of a 10 bed alongside midwifery-led unit (AMU) in 2012 and newer technology, such as wireless fetal monitors, has led to improved patient satisfaction, lower intervention rates and lower caesarean section rates.

Improvements in increasing rates of normal deliveries at Newham Hospital

The aim is to reduce the caesarean section rate by approximately 5% by the end of 2021, from the current trust-wide 28% to 23%. This is in line with the best performing acute trust in London.

#### 7.6 Investment costs

In order to implement the model of investments will include capital requirements, workforce investment, project implementation costs, organisational development (OD) costs and investments in IT. Further narrative of the workforce and estate investment required is provided below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital (estates/ IT/ equipment etc)</td>
<td>£0.01m</td>
<td>£0.01m</td>
<td>£0.01m</td>
<td>£0.01m</td>
<td>£0.01m</td>
<td>£0.05m</td>
</tr>
<tr>
<td>Maternity workforce Project implementation costs</td>
<td>£1.86m</td>
<td>£2.32m</td>
<td>£2.73m</td>
<td>£3.04m</td>
<td>£3.4m</td>
<td>£13.38m</td>
</tr>
<tr>
<td>OD costs</td>
<td>£0.2m</td>
<td>£0.17m</td>
<td>£0.07m</td>
<td></td>
<td></td>
<td>£0.43m</td>
</tr>
<tr>
<td>Informatics</td>
<td>£0.2m</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£0.2m</td>
</tr>
</tbody>
</table>
7.7 Workforce

In order for this change programme to be a success, it will need to be supported by a sustainable and highly skilled workforce. Engagement across Barts Health has highlighted the varying approaches to workforce planning, influenced by differing resources and recruitment processes. This variation will directly affect the trust's ability to provide a universal model of maternity care.

Many improvements in approach have already been made, including a reduction in both vacancy rates and agency spend in relation to midwifery staffing. This is commendable but needs to be complemented by the development and implementation of a strategic trust-wide approach to maternity and newborn care workforce. This will ensure sustainability in meeting future demand for care safely, and address the current concerns raised by the CQC.

In assessing the impact of increased birth numbers on workforce, there has been use of the midwife:birth ratios agreed at each site, as well as the strategic aims of the trust in respect to hours of obstetric consultants on-call. There is a recognition of the important role midwifery care assistants play in the provision of high quality maternity care and this will be developed in future planning.

Consultant obstetricians

Following discussions with the lead obstetrician at Barts it has been concluded that it is reasonable to aspire to 98 hours of consultant cover per week in line with acute trusts across London. This will require a further 6.5 Full Time Equivalent (FTE) obstetric consultants across three sites, as described in the table below. This increase also enable the safe and effective management of the increasing demand expected in antenatal and postnatal clinics over the next five years.

<table>
<thead>
<tr>
<th>Site</th>
<th>FTE obs/gyn consultants in post 15/16</th>
<th>Obstetric cover (hrs) 15/16</th>
<th>FTE obs/gyn consultants required</th>
<th>New obstetric FTE total</th>
<th>Obstetric cover (hrs) 20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barts Health total</td>
<td>40.5</td>
<td>82</td>
<td>7.5</td>
<td>48</td>
<td>98</td>
</tr>
<tr>
<td>Whipps Cross</td>
<td>13</td>
<td>80</td>
<td>3</td>
<td>16</td>
<td>98</td>
</tr>
<tr>
<td>RLH</td>
<td>12.5</td>
<td>84</td>
<td>3.5</td>
<td>16</td>
<td>98</td>
</tr>
<tr>
<td>Newham</td>
<td>15</td>
<td>94</td>
<td>1</td>
<td>16</td>
<td>98</td>
</tr>
</tbody>
</table>

Midwifery workforce

The recent CQC inspections of the service identified concerns regarding staffing on each site and led to Barts Health developing an internal 'safer staffing' initiative. This included a review of midwife to birth ratios, which were discussed and agreed with local commissioners and members of each midwifery service liaison committee. The agreed ratios were informed
by the findings in the Barts Health Birthrate Plus report\textsuperscript{121} which included acknowledgement of the increased post-natal activity for out of area births at both the Whipps Cross and Newham sites.

The tables below indicate the numbers of midwives each site will need to recruit to meet the safer staffing midwife: birth ratios they have agreed, based on the numbers of births forecast for each year over the next five years.

However, in order to meet the agreed ratios based on the forecasted birth activity for 2015/16, Barts needs to recruit 63 FTE midwives by March 2015/16 which will be before the implementation phase of the OoOU initiative has commenced. It is understood that this funding has been agreed.

From April 2016 onwards, a further 43 FTE midwives will be required to maintain safe staffing levels in relation to the safe staffing ratios agreed phased over the 2016 to 2021. This will require investment in maternity workforce of £11,834,742 (see part 3, section 7.6).

\textsuperscript{121} Barts Health NHS (2014) Birthrate Plus report.
Once the required resource has been agreed, the challenges of future recruitment and strategies for sustaining the workforce in safe numbers will reduce if Barts Health moves to capitalise on the predicted over-supply of newly qualified midwives by attracting and supporting staff to work in the East London area. However, this is only if the right conditions can be created to attract new staff to the area and retain those that are already employed. Part of the organisational development resource will be used specifically to engage with midwives, to understand how the model of care can be changed whilst ensuring work-life balance is maintained, if not improved.
Other maternity workforce requirements

As the CQC also identified data quality as an area of concern for Barts Health, resource for three FTE information technology specialist midwives has been included in the costs to deliver the changes described in this document. This is to support improvements in data entry and reporting by ensuring all maternity staff enter data consistently, and maternity information and communications technology requirements are given the necessary priority in the organisation.

Further exploration into how the role of midwifery care assistants (MCAs) will support the implementation of midwifery continuity of care is also required. Both the number of FTE MCAs and future development of the role will need to be considered as the improved model of maternity care is operationalised. Nationally, it is recommended that the number of FTE MCAs required to deliver high quality maternity care is 10% of the midwifery establishment. It has been highlighted that at one Barts site the FTE of MCAs is as high as 30% of the midwifery total and therefore more work is required to understand this variation.

7.8 Estates

The capital resource of £218,222 is allocated to the estate requirements explained below. This currently excludes the costs of the new Royal London Hospital alongside midwifery unit (AMU) being refurbished and open by 1 April 2016. If this position changes, the costs associated with developing this unit will need to be factored into the TST 2016/17 year-end financial position.

Whipps Cross

Neither the obstetric unit nor the AMU is currently fit for purpose and this will affect the choices women make about where they wish to deliver their babies. Whilst discussions around the future of the Whipps Cross site development are in progress, it has been recognised that resource is urgently required to ensure that the ambitions of increasing the number of babies born in the AMU are realised. This includes ensuites for all obstetric delivery rooms, the addition of birthing pools in the AMU rooms that are already in use, and the refurbishment of a further two rooms to give the unit the extra capacity it needs to meet future AMU demand. Resource for converting any OU capacity that might be released is not yet available.

Royal London

The capital costs for the development of the AMU at the Royal London Hospital have not been included in these figures as the project started before TST. Should this not form part of Barts Health’s capital plans for 15/16, this figure will then need to be included in the investment costs shown in part 3, section 6. A high level estimate for capital costs is £6 million.

Resource has been included for the addition of equipment at the Barkantine to ensure the birthing pools are fit for purpose.
Newham

Whilst capacity will be released in the OU, the costs associated with converting this for AMU use is not available.

7.9 Impact on activity and finance: Increasing births outside obstetric unit

Impact on activity

The increase in the number of births being supported outside of obstetric units through the provision of continuity of care creates a more sustainable and efficient maternity system for the future. The ambitions in relation to the shift of activity out of obstetric-led units that have been agreed across settings are set out in part 3, section 7.5. The three tables below articulate the phasing of these shifts across all care settings and the impact of the shifting activity on capacity. Narrative regarding the impact on each setting is provided below.

Obstetric units

The graph shows that over the next five years, intrapartum demand in the obstetric units will move from the current over-capacity (835 births) in 2015/16, to one where demand on the units will be reduced by 2,281 births by 20/21. Some of this capacity released will need to be converted for midwifery-led care, particularly for Newham.

Impact of increasing the number births outside of obstetric units on Barts Health capacity over the next five years

<table>
<thead>
<tr>
<th></th>
<th>Birth activity BHT 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHT OU</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14,100</td>
</tr>
<tr>
<td></td>
<td>14,935</td>
</tr>
<tr>
<td></td>
<td>12,654</td>
</tr>
</tbody>
</table>

*The capacity of all birth settings have been agreed by BH clinical leads from each site

The reduction in obstetric unit activity will also lead to a reduction in maternity length of stay as there will also be a reduction in both Caesarean-sections and admissions to postnatal wards on acute site. This should create an opportunity for Barts Health to shift some workforce resource currently required to staff obstetric unit demand to other maternity care settings. The rate at which this could be achieved is not yet known.
**Midwifery-led units (includes birth centres and alongside midwifery units)**

Prior to agreeing the ambitions of increasing the number of births outside the obstetric units, it was discussed and agreed to treat capacity of both the alongside midwifery units and the two freestanding birth centres (otherwise known as Freestanding Midwifery-led Units) as one entity. This is in line with recent evidence that suggests the risk profiles of the two cohorts of women who are likely to use these settings are very similar, with a different criteria now set for home births based on the emerging evidence of the birthplace study.

The table below shows the phasing of the increase in births across midwifery-led units, and when they will reach their capacity.

<table>
<thead>
<tr>
<th>MLU site</th>
<th>Capacity 15/16 (births p.a.)</th>
<th>No. of MLU births 14/15 (% of all births at each site)</th>
<th>Projected increase of MLU births Y1</th>
<th>Projected increase of MLU births Y3</th>
<th>Projected increase of MLU births Y5</th>
</tr>
</thead>
<tbody>
<tr>
<td>WXH</td>
<td>1000</td>
<td>249 (5%)</td>
<td>800 (16%)</td>
<td>1200 (24%)</td>
<td>1422 (28%)**</td>
</tr>
<tr>
<td>RLH*</td>
<td>2100</td>
<td>602 (11%)</td>
<td>1202 (21%)</td>
<td>1516 (25%)</td>
<td>1709 (27%)</td>
</tr>
<tr>
<td>NUH</td>
<td>2000</td>
<td>1403 (20.5%)</td>
<td>1700 (24%)</td>
<td>2000 (28%)</td>
<td>2647 (37%)</td>
</tr>
</tbody>
</table>

*The RLH MLU capacity relies on the new AMU being open in April 2016.

**Provided the resource in both workforce and estates are agreed to ensure two birth suites on AMU can be opened by Y3, WXH AMU will not reach capacity until Y5. This assumes further two birth suites increase capacity of the unit to approximately 1400 births p.a. Further analysis to inform future demand and capacity modelling will be taken forward through the North East London Maternity Network (NELM).

With the exception of the Newham midwifery-led settings, all other sites have the physical capacity to absorb the expected shifts in activity from the obstetric unit provided estates and workforce investment is agreed. Newham will need capacity for 647 more births by 2020/21, which could be sourced from the capacity released in the obstetric units over time.

**Home birthing team capacity**

The capacity of the home birth offer for each site depends on the number of personnel in each team, how they are organised, and whether they are included in the on-call escalation policy for each obstetric unit. The table below describes the capacity of the teams currently, and how these need to grow to ensure the ambitions for increasing the home birth offer to women can be achieved.

<table>
<thead>
<tr>
<th>Current capacity and HB activity</th>
<th>Future home birth aspirations and team growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site</td>
<td>Capacity 15/16</td>
</tr>
<tr>
<td>-------</td>
<td>----------------</td>
</tr>
<tr>
<td>WXH</td>
<td>100</td>
</tr>
<tr>
<td>NUH</td>
<td>120</td>
</tr>
<tr>
<td>RLH</td>
<td>?*</td>
</tr>
</tbody>
</table>
*RLH does not have a separate home birth team however may develop this in the future to achieve its ambition of 3% home births in TH.

There are currently eight FTE midwives working in home birth teams across Newham and WXH. Over the next five years, the midwifery workforce will need to be supported to increase to 35 FTEs to achieve the ambition of 5% home births across the Barts Health footprint, based on the current capacity calculations.

**Summary: Impact of activity shifts across all sites and settings.**

*Whipps Cross*

<table>
<thead>
<tr>
<th>Capacity p.a</th>
<th>Activity14/15</th>
<th>Y1 16/17</th>
<th>Y3 18/19</th>
<th>Y5 20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births Forecast</td>
<td>4979</td>
<td>5025</td>
<td>5064</td>
<td>5091</td>
</tr>
<tr>
<td>OU</td>
<td>4000</td>
<td>4680 (94%)</td>
<td>4125 (82%)</td>
<td>3646 (72%)</td>
</tr>
<tr>
<td>MLU</td>
<td>1000</td>
<td>249 (5%)</td>
<td>800 (16%)</td>
<td>1215 (24%)</td>
</tr>
<tr>
<td>HB</td>
<td>100</td>
<td>50 (1%)</td>
<td>100 (2%)</td>
<td>203 (4%)</td>
</tr>
</tbody>
</table>

*Newham*

<table>
<thead>
<tr>
<th>Capacity p.a</th>
<th>Activity14/15</th>
<th>Y1 16/17</th>
<th>Y3 18/19</th>
<th>Y5 20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births Forecast</td>
<td>6845</td>
<td>7016</td>
<td>7120</td>
<td>7155</td>
</tr>
<tr>
<td>OU</td>
<td>5100</td>
<td>5408 (79%)</td>
<td>5246 (75%)</td>
<td>4978 (70%)</td>
</tr>
<tr>
<td>MLU</td>
<td>2000</td>
<td>1403 (20.5%)</td>
<td>1700 (24%)</td>
<td>2000 (max capacity) (28%)</td>
</tr>
<tr>
<td>HB</td>
<td>120</td>
<td>34 (0.5%)</td>
<td>70 (1%)</td>
<td>142 (2%)</td>
</tr>
</tbody>
</table>

*Royal London Hospital*

<table>
<thead>
<tr>
<th>Capacity p.a</th>
<th>Activity14/15</th>
<th>Y1 16/17</th>
<th>Y3 18/19</th>
<th>Y5 20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births Forecast</td>
<td>5477</td>
<td>5737</td>
<td>6045</td>
<td>6328</td>
</tr>
<tr>
<td>OU</td>
<td>5000</td>
<td>4847 (88.5%)</td>
<td>4474 (78%)</td>
<td>4412 (73%)</td>
</tr>
<tr>
<td>MLU</td>
<td>2100</td>
<td>602 (11%)</td>
<td>1202 (21%)</td>
<td>1516 (25%)</td>
</tr>
<tr>
<td>HB</td>
<td>n.a*</td>
<td>27 (0.5%)</td>
<td>57 (1%)</td>
<td>114 (2%)</td>
</tr>
</tbody>
</table>

*RLH does not have a separate home birth team however may develop this in the future to achieve its ambition.*

**Impact on finance and sensitivity analysis**
After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net cost of between £13.7m to £14.1m over a five year period.

Whilst there are some savings in relation to the shift in activity from acute obstetric units to midwifery led settings (approximately £55k - £61k over 5 years), this is negated by the investment required to transform the current model of care being provided to ensure choice in birthplace is fully implemented and staff have the right support in place to work very differently.

Although this scheme results in an increase in costs, this changes proposed are beneficial to the system as a whole. It will ensure more births take place in non-obstetric settings, allowing forecast demand to be absorbed safely and without the need for increasing capacity in obstetric-led units in the future.

7.10 System commercial considerations and transitional support required

Issues around the provision of maternity care in relation to both quality and demand for services are shared by all providers in the wider north east London health economy. The anticipated increase in demand for maternity care is expected to be across the whole of the north east London health economy not simply Barts Health.

This strategy does not diminish the importance of continuing to review and manage demand for services across this wider footprint. This approach must work with the known interdependencies between Trusts to implement solutions that offer mutual support and efficiency across north east London as a whole.

This work will be continued via the clinical senate and maternity network and will require continued engagement by CCGs and providers in a collaborative fashion.

The roles of the North East London Maternity Network (NELMN) and Head of Maternity Commissioning for north east London will be integral to ensuring that there is coherence across the region’s workstreams, allowing Transforming Services Together to continue to align with the ambitions of all north east London providers, as well as the strategic direction of the Pan London Maternity clinical network.

One important example of the need for inter-related thinking is in demand and capacity management. All providers have limited capacity to provide care for women and therefore managing excess demand needs to be a system wide concern.

Any large-scale change to service provision and capital development will need to adhere to NHS procurement guidelines.
### 7.11 Delivery risks

The risks described below are associated with the practical delivery of changes to the current provision of maternity care.

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable, validated maternity data set across all Barts sites continues to be unavailable due to BH Cerner system configuration and knowledge of users. Lack of reliable data is likely to inhibit accurate measurement of progress against predicted activity shifts for OoOU initiative</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Perinatal Network to include informatics within membership, highlighting clear lines of accountability for mitigating risk in relation to ICT</td>
</tr>
<tr>
<td>There is a risk BH will not agree to resource the increase in FTE midwifery staff to meet safer staffing initiative midwife:birth ratios agreed at all BH sites</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Project manager to discuss gap in midwifery FTE with programme director for the Maternity work stream and agree process for raising this through new Barts TST governance arrangements</td>
</tr>
<tr>
<td>There is inconsistency in project management resource across BH sites to ensure effective implementation and delivery of strategic vision for maternity and newborn care. This will impact negatively on the shift of births OoOU</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Project management resource for each Barts site requested to support Perinatal Network and clinical leads at each site throughout implementation</td>
</tr>
<tr>
<td>There is a risk that midwives in Barts may not wish to be on-call for OoOU births. This may restrict the deliverable options of midwifery continuity of care models in the future</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Organisational development resource requested to ensure the right level of engagement in development of midwifery continuity of care model to mitigate this risk</td>
</tr>
</tbody>
</table>
5. Operationalising Continuity of Care Across All Settings

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Head of North East London Maternity Commissioning has raised risk at NEL clinical senate in November and to raise at first meeting of the North East London Maternity Network (NELM) in Jan 2016.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Queens Hospital continues to cap number out of area antenatal bookings. This may increase the number of women booking at BH or Homerton sites which will affect capacity planning in TST strategy</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Queens Hospital continues to cap number out of area antenatal bookings. This may increase the number of women booking at BH or Homerton sites which will affect capacity planning in TST strategy</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>The AMU at the RLH and the redevelopment of the new AMU at Whipps Cross (WX) in the Barts strategy have been repeatedly deprioritised. If they are not realised the ambitions for increasing OoOU births will not be realised</td>
<td>Project manager to discuss process for ensuring AMU at RLH remains on track to open April 2016 through BH women and children’s Clinical Academic Group (CAG) with maternity programme director. TST steering group to acknowledge risk of not making WX site fit for purpose in relation to birthing pools at AMU and ensuites in OU rooms.</td>
</tr>
<tr>
<td>3</td>
<td>Maternity leadership within BHT has not yet agreed universal standards for continuity of care or commenced staff engagement continuity of care models. This places the timescale for submitting business case for model of care by end of March at significant risk.</td>
<td>Risk has been raised with Work stream executive. Telecall to be arranged with maternity programme director to discuss potential mitigations.</td>
</tr>
</tbody>
</table>

7.12 Next steps

In order to take this work forward we want to rapidly build on the strong level of engagement with the lead clinicians at each site to progress this work in the following ways:

<table>
<thead>
<tr>
<th>Phase</th>
<th>Outline</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development and validation of midwifery continuity of care model (MCOC)</td>
<td>Work with clinical leads to engage with all maternity staff at each site to ensure model develops with their expertise and opinions</td>
<td>Dec 2015- January 2016</td>
</tr>
<tr>
<td>Identification of project delivery leads at each site and associated governance and reporting mechanisms</td>
<td>Work with TST maternity clinical leads to prioritise work plan to ensure streamlined delivery of TST objectives and minimise duplication across sites</td>
<td>Jan 2016</td>
</tr>
<tr>
<td>Understanding impact of developing new model of transitional care</td>
<td>Support clinical leads to identify benefits of developing a dedicated transitional care ward in terms of reducing inpatient length of stay on maternity units and reduction in demand for special care</td>
<td>Dec 2015 – Jan 2016</td>
</tr>
<tr>
<td>Public engagement</td>
<td>Work with TST Patient and Public Reference Group (PPRG) and Healthwatch to develop proposals in line with any patient concerns</td>
<td>Jan 2016</td>
</tr>
<tr>
<td>Implementing the improved model of care</td>
<td>Using agreed model working with clinical leads at each site to understand impact of new model on existing midwifery workforce. Identify potential staff consultation requirements</td>
<td>Feb 2016 (ongoing)</td>
</tr>
<tr>
<td>Development of maternity networks in primary care</td>
<td>Working with maternity leads identify resource for developing self-sustainable maternity networks for each borough to support shift in culture to one that values normality</td>
<td>Feb 2016</td>
</tr>
<tr>
<td>Business case for refurbishment of WXH maternity settings</td>
<td>Detailed capacity and demand analysis – to inform capital expenditure on necessary estates changes</td>
<td>March 2016</td>
</tr>
<tr>
<td>Business case for increased FTE maternity staff to meet safe staffing requirements</td>
<td>Detailed workforce modelling to be undertaken to understand FTE required at each site and birth setting and phasing at which this needs to occur</td>
<td>March 2016</td>
</tr>
</tbody>
</table>

### 7.13 Governance arrangements

Throughout Winter 2015/16, BH will be establishing a new governance structure to take forward the clinical strategy at each site (see figure below). The trust’s maternity and newborn care leaders have identified there is a need to develop a culture that is strongly committed to providing normality for all women, across all sites and professions, as well as within the communities they support. It is also the understanding that these key themes within the BH strategy will be further supported by the recommendations from the National Maternity Review being led by NHS England, due for publication in December 2015.

To ensure the organisation develops in line with its strategic aspirations with regards to the out-of-obstetric unit birth initiative and its quality improvement plans, the Perinatal Network will oversee the delivery of this ambitious change programme. Members of this network and associated site-based working groups will need to be supported to develop both the
implementation and delivery plans set out in this document via ongoing support from the relevant CCGs and TST programme team over the next five years.

Barts Health TST governance structure for delivery of maternity and newborn care initiatives

The first meeting of the Perinatal Network was held on 30 October 2015, where its roles and responsibilities and those of its members were discussed and agreed. It will be a key role of the Barts Health Perinatal Network Board to define further the universal Midwifery Continuity of Care model (MCOC) throughout Winter 2015/16. This will require strong engagement with the midwives at each site who need to recognise the importance of providing an equitable model of maternity care across Barts Health sites, and therefore they may be required to work in different ways to ensure full implementation.
8: Transform the patient pathway and outpatients

8.1 The case for change

In 2014/15 hospitals provided 1,406,000 outpatient appointments to East London residents. By 2020/21, if we do nothing, this figure is likely to grow to 1,547,000 due to population growth.

Each appointment represents a patient journey from home to hospital and back again. In many cases this can mean time off work or out of education and training. Standard consultations are short; follow up appointments – not always with the same healthcare professional – are booked far in advance and are not necessarily in sync with developments in the patient’s condition. In addition, patients that need urgent specialist advice are not always able to access it as quickly as they would like. As part of our engagement, many clinicians have told us that outpatient care could be delivered much more effectively.

The Transforming Services Changing Lives (TSCL) Case for Change identified seven key areas for improvement to pathways across primary, community and acute care:

1. We need to focus more on early identification and prevention

For example, in over 90% of cases, the risk of having a first heart attack is related to modifiable risk factors including smoking, insufficient physical activity and obesity. Addressing diet, physical inactivity and smoking to reduce cardiovascular disease also helps to reduce the risk of other chronic conditions, such as type 2 diabetes, liver disease and some types of cancer. Public Health data estimates that 72,310 people in East London are have pre-diabetes, some of the highest levels in the country122. Gaps between expected prevalence rates and those diagnosed need to close so that patients on primary care disease registers can receive the support they need to manage and stay in control of their conditions.

2. A significant number of referrals to secondary care could be managed in a more effective way

Discussions with specialists have suggested that up to 20% of new patients attending orthopaedic outpatient clinics are discharged after the first appointment with no follow up being required. This indicates that some patients may be better managed by primary and community care services. Quick access to immediate specialist advice for GPs via the telephone has been shown to avoid significant numbers of inappropriate referrals and admissions: a 2012 pilot in Bristol found that referral or admission to hospital could be avoided in 56% of cases123.

3. The referral to treatment process, including diagnostics, could be more streamlined

The TSCL Case for Change identified that some people wait a long time for their appointments and that some patients have to attend multiple visits before a diagnosis is

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made and treatment begins. Barts Health is currently not meeting 18 week referral-to-treatment (RTT) targets across a number of specialties.

4. **Models of outpatient care for follow up can be ineffective**

Patient engagement during the development of the *Case for Change* highlighted people’s frustration at the need to travel and take time away from work for simple and quick outpatient follow-up appointments. In addition, clinicians have expressed concern that standard 10-minute follow up appointments do not always add value.

5. **Patients can’t always access specialist advice when they most need it**

In some cases the only option for patients suffering an exacerbation of an existing long-term condition or experiencing new symptoms is to attend emergency departments. This can result in avoidable admissions to a hospital bed as this is the default way in which immediate access to specialist opinion is provided in the current system.

6. **We don’t always support patients to understand and manage their condition**

There is large variation in hospitalisation for people with ambulatory care-sensitive conditions. These are conditions such as diabetes, asthma or congestive heart failure where better management or earlier treatment could prevent admission to hospital.

7. **A large number of patients do not attend outpatient appointments**

Health services should make it easier for patients to attend appointments when they need to happen. Current ‘did not attend’ (DNA) rates reach 20% in some specialties. Sometimes this happens because patients find it difficult to attend or let staff know that appointments need to be re-arranged. Tackling this problem is important because for every patient who doesn’t attend, another then has to wait longer to get the care they need.

In summary, the message from local clinicians is clear: we need to redesign pathways and be much more ambitious in our future vision of outpatient care.

8.2 **Model of care**

This transformational scheme will build upon existing improvement work and by 2020/21 reduce outpatient appointments by 20% across all pathways so that local providers can meet demand expected due to population growth, whilst improving patient experience and reducing waiting times.

This change will be achieved through two overarching strands of work:

(i) **Transforming long term conditions (LTC) pathways**: projects that will improve high volume LTC pathways in line with our integrated care vision

(ii) **Transforming planned care pathways**: projects that will transform high volume planned care pathways such as Musculo-Skeletal and dermatology services.

As highlighted by the diagram below a 10% reduction will come from reducing unnecessary referrals to hospital, whilst a 10% reduction will come through face-to-face appointments being provided in innovative new ways.
Planned reduction in outpatient activity

The diagram below summarises the changes we are proposing. Clinicians from primary, community and acute services have been involved in determining the approach. Alongside patients, clinical leadership will continue to be integral to the design and development of the new processes and pathways.

Pathway transformation initiatives

Cross-cutting changes for all high volume specialties:
- Every contact counts
- Specialist advice for GPs
- Standardised referral criteria and standards
- Electronic referral process
- Specialist hubs and clinics in the community
- Telemedicine advice
- Straight to test and access diagnostics for primary care
- One stop clinics
- Streamline pre-operative assessment
- Reduce DNAs
- Ambulatory assessment clinics
- Telephone and Skype appointments
- Primary and community services with alternative workforce options
- Clinical communities and networks

In addition, for long term conditions pathways we will consider:
- Prevention programmes for those at risk
- Long term medicines monitoring in the community
- Patient education
- Telehealth monitoring systems
- Patient-initiated review

*RTT = referral to treatment initiation
1. **We will build prevention and early intervention into each redesign project**

In redesigning all high volume specialities, we will:

- Learn from and develop the local ‘Making Every Contact Counts’\(^{124}\) strategy with input from public health staff so that we make use of the opportunities arising from everyday contact in each pathway so all clinicians can promote healthy living.

In redesigning long term conditions pathways, we will:

- Work with public health to support programmes that prevent or delay the development of cardiovascular disease, respiratory disease and type 2 diabetes, identifying regional programmes that can reduce risk factors.

*Making Every Contact Count* is a national vision that we will build on with the support of local public health teams. The *NHS Future Forum (2012)\(^{125}\)* recommended that every health care organisation should implement it and build on the role that the NHS has in health promotion. Every day GPs and practice nurses across the UK see over 800,000 people and therefore have an opportunity to influence healthy living and encourage people to modify their behaviour.

An example of the way we intend to improve prevention is the way in which public health and CCG leads across East London are working together to develop a local approach to the National Diabetes Prevention Programme. This programme offers behavioural support for people with non-diabetic hyperglycaemia, who are at high risk of developing type 2 diabetes. International evidence indicates that a 58% reduction in the risk of developing diabetes can be achieved through this type of intervention\(^{126}\).

To achieve these changes we will need to:

- work with public health to develop targeted local prevention strategies for high impact pathways
- engage and work with primary and community care providers through new provider models to strengthen preventative care and support.

2. **We will increase the quality of referrals and improve access to specialist advice**

Providing improved access to specialist advice is important because the clinicians we have spoken to say that primary care teams do not have the support they need from the wider health care system to coordinate care for people with long term conditions. This is backed up by national evidence, with a key Kings Fund paper on referral management recommending the development of opportunities for informal advice from specialists\(^{127}\). Interventions such as these have been shown to work nationally. For example, Imperial College’s Connecting Care for Children (CC4C) email advice evaluation showed that half of queries resulted in advice that enabled GPs to continue patient care and avoid referral; 82% of GPs using the system agreed that it had reduced referrals


\(^{127}\) The Kings Fund (2010) Referral Management
Within the East London region, current provision of specialist advice to GPs is variable both by region and specialty. By standardising these services, we are likely to achieve reductions in referrals for high volume conditions. This standardisation should consider implementing single points of access for both phone and email advice which can transfer enquiries to the relevant specialty.

In some cases, telemedicine can be used to support the provision of specialist advice. Telemedicine for in Tower Hamlets is helping us understand how we can improve care for patients. Early indications suggest allowing GPs to access specialist opinion in primary care settings more easily will enable new ways of working. In Scotland, an ophthalmic triage system with digital imaging of the eye led to a reduction of 14% in new referrals.

In addition to providing specialist advice, referral guidelines and processes will be standardised across the region to simplify the system. These referral guidelines will also clarify the diagnostic tests that should be carried out before the first appointment. This will ensure that outpatient referrals add value and that consultants are able to make decisions about treatment sooner.

For appropriate high volume pathways, we will consider the creation of local centres of specialist expertise at primary care hubs to provide extended services to local populations. By creating local centres of expertise we will benefit from economies of scale allowing greater service provision in the community. For example, we will develop community centres of expertise for some MSK services to increase access to physiotherapy, psychological support and pain management in the community.

We plan to develop knowledge and capacity in primary care to enable the management of less complex, high volume conditions without the need for hospital outpatient appointments. This will improve patient experience and enable specialists to focus on more complex cases. Close working with primary care will be vital to rolling out these processes, as well as their involvement at redesign events.

In summary, across all high volume specialties, we will:

(i) provide access to specialist advice for GPs via telephone, email or telemedicine
(ii) agree standardised referral criteria across the region and implement triage rules to ensure adherence
(iii) increase efficiency by ensuring that electronic referral processes are built into the pathway
(iv) enable primary care hubs, through the support of specialists to manage simple conditions in the community. For example, this model will be appropriate for extended MSK and gynaecology services.

To achieve these changes we will need to:

- deliver improvements to technology to enable new ways of working
- define new referral pathways and strengthen links with community and primary care providers
- develop new provider models to enable vertical integration and closer working between acute and community services
- develop new payment systems that support organisations and teams to work together and create new clinical practices across boundaries.
3. **We will streamline the referral to treatment process**

The referral to treatment process needs to be streamlined in order that waiting times are shorter, waste and duplication is reduced and patient experience of services improves.

Whilst much of this will focus on outpatient transformation work at Barts Health, primary care will also be empowered to care for more patients without the need for a referral through providing quicker access to direct diagnostics (a referral in which GPs only refer to Barts Health diagnostic services and receive the result directly). We will also develop straight-to-test pathways that will allow primary and community practitioners to request tests prior to the first patient appointment with a specialist. This reduces the time patients need to wait for diagnosis and treatment and ensures that the appointment with the specialist is used most effectively.

In some circumstances, we may increase the equipment available in community settings. For example, chronic obstructive pulmonary disease diagnosis requires spirometry assessment, but not all primary care practices have access to the equipment and expertise to take these measurements. Ensuring that future primary care hubs have access to this kind of equipment could reduce unnecessary referrals.

The Barts Health outpatient transformation programme has already achieved a reduction in the time from referral to diagnosis through the implementation of lean principles (a system for service improvement centred on value for patients) and the development of one-stop clinics. For example, a one-stop clinic was established at Barts Health for rheumatology that reduced waiting time from referral to treatment to two weeks. This programme will be accelerated with a focus on high volume specialties where the greatest need to reduce waiting times has been identified.

We will also reduce the number of appointments required before treatment through a cross-cutting programme to reduce multiple pre-operative visits and consider alternative models (such as telephone or internet-based appointment) for these assessments. We are continuing to develop these pathways in collaboration with the TST surgery workstream (see part 3, section 5).

High patient DNA rates need to also be addressed. Musculoskeletal, ophthalmology and cardiology specialties have DNA rates above 20%, as well as provider cancellation rates of 10-15%. A clear improvement strategy will be implemented as this level of DNAs generates inefficiencies in the appointment booking process and leads to unused capacity.

In summary, we will:

- develop direct access to diagnostics and straight-to-test pathways ensuring that best practice protocols are built into these pathways to prevent unnecessary testing
- expand the Barts Health outpatient transformation programme to reduce unnecessary delays in referral to treatment time
- work with the surgery workstream to streamline pre-operative processes. We will seek to incentivise best practice pre-operative assessment through our contracts.
- identify and address causes of patient ‘did not attends’ (DNAs) and provider cancellations to increase the proportion of appointments attended and increase ‘right first time’ booking. Technological solutions which allow patients to book and reschedule online should be considered as part of this improvement work.
4. **We will implement new models of care for outpatient follow up**

New models of outpatient follow up are required in order to avoid unnecessary trips to hospital and back and improve patient experience of care. Telephone and Skype clinics for conditions such as diabetes have already been trialled in East London, have meant more effective use of clinical time and resulted in good patient feedback. The use of these types of clinics will be expanded to provide more convenient options for patients. Further work will take place to develop payment systems that adequately compensate providers for offering these types of services as this is recognised as an important barrier to widespread adoption.

We will utilise allied healthcare practitioners, including physiotherapists, optometrists and pharmacists, to support primary and community care in the treatment and follow-up of patients. In Waltham Forest, community optometrists already carry out long term monitoring of patients with glaucoma. The Royal College of Ophthalmologists indicates that there is also a role for community optometrists in post-operative follow-up of cataract surgery.

We will consider opportunities for expanding the primary and community role in monitoring long term medication for patients with long term conditions. In Newham, community pharmacists run a service to monitor anti-coagulant drugs for patients with atrial fibrillation. This service has been running since 2010, and is soon to be extended to enable community initiation of this medication. East London medicines management teams are currently working together to set up a similar primary or community-led service to monitor disease-modifying anti-rheumatic drugs.

In summary, for all high volume specialties, we will:

- implement alternative models of outpatient follow-up with appointments available via telephone and internet-based tools, such as Skype
- where appropriate, consider alternative workforce groups and approaches that could support primary and community care to treat and follow-up patients.

For long term conditions redesign, we will:

- identify long term medications that could be safely and effectively monitored in community or primary care settings to reduce the number of outpatient follow-up appointments that patients with long term conditions need to attend.

To achieve these changes we will need to:

- deliver improvements to technology to enable new ways of working for example allowing patients to view their own records and booking or managing appointments
- develop payment mechanisms to reward new clinical practice across boundaries.

5. **We will better support patients to understand and manage their own conditions**

In order to develop patients’ confidence to stay in control of their own long term conditions, staff need to be supported in offering behavioural change approaches that encourage self-care and self-management. For conditions such as diabetes, there are strong networks of specialists, GPs and other health professionals already in place who work together to share best practice and discuss the best approaches to patient management. Networks need to be developed in all high volume specialties over the coming years to facilitate communication and disseminate best practice, including via online portals.
A 2014 review by Health Education North Central and East London identified several patient self-care support programmes including activities focused on asthma, COPD, diabetes, and pain management\textsuperscript{128}. The recommendations from this review will be considered in the expansion and development of new local education programmes. A King’s Fund report on long term conditions and mental health also highlights the benefits of building psychological support into condition-based education programmes\textsuperscript{129}. Co-morbid mental health problems raise total healthcare costs by at least 45\% for each person with a long term condition and co-morbid mental health problem. Therefore, considering this element within the design of future programmes will realise benefits in financial sustainability as well as patient outcomes.

In the \textit{Case for Change}, patients said that they would be happy to use technology to monitor their condition at home, as this is how many of them manage the rest of their lives. We will increase the use of home monitoring systems for long term conditions where possible, and support record sharing and patients uploading their own results to their health records (e.g. blood pressure monitoring).

Administrative processes also need to change to allow patients to have more control about when they access services, depending on exacerbations in their long term conditions. By supporting them to defer and rebook outpatient appointments that better suit their needs we are likely to reduce DNAs and provide patients with a better experience of care. A six year study by Bristol Royal Infirmary of patient initiated reviews for rheumatoid arthritis showed a reduction in unnecessary follow-up appointments and more efficient use of resources, while maintaining patients’ physical and psychological status\textsuperscript{130}.

In summary for all high volume specialties we will:

- develop clinical communities and networks to provide primary and secondary care professionals with more opportunities to share learning and improve patient care

For patients with long term conditions we will:

- develop self-care education programmes that support patients to avoid the worsening of cardiovascular conditions, COPD and diabetes
- when appropriate, use and develop tele-healthcare monitoring systems that input into shared care records to enable patients to monitor their condition
- enable patients to initiate and defer follow-up appointments to reflect their needs.

To achieve these changes we will need to:

- work with patients to design new ways of accessing healthcare that work better for them
- deliver improvements to technology to enable new ways of working
- develop payment systems that reward innovative clinical practice.

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\textsuperscript{128} Supporting the Education and Empowerment of Patients and Carers. Health Education North Central and East London 2014.

\textsuperscript{129} Long-term conditions and mental health. The King's Fund 2012.

8.3 Engagement
The following stakeholders have been engaged to inform this strategy:

- Commissioning leads for Newham, Tower Hamlets and Waltham Forest
- GP representatives for Newham, Tower Hamlets and Waltham Forest
- Barts Health Primary Care Team
- Clinical Director for Cancer Improvement, Barts Health NHS Trust
- Medical Director, Whipps Cross Hospital
- Barts Health Service Improvement Team
- Barts Health general management: MSK, diabetes, renal
- Public Health Directors at East London Local Authorities and Barts Health
- TST Board
- TST Clinical Reference Group
- TST Workstream Executive
- Regular contact and collaboration with key co-dependent TST workstreams

This strategy builds on the patient engagement that took place as part of Transforming Services Changing Lives\(^{131}\). In addition, our approach to pathway redesign will be further tested with the TST Public and Patient Reference Group and we are committed to patients being intrinsically involved in redesign events.

8.4 Outcomes the change will achieve
Our proposed model of care is intended to achieve the following outcomes:

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% Reduction in hospital based outpatient appointments against 2015/16 baseline</td>
<td></td>
</tr>
<tr>
<td>(excluding population growth) made up of the below initiatives.</td>
<td></td>
</tr>
<tr>
<td>- Absolute reduction in initial referrals to secondary care</td>
<td></td>
</tr>
<tr>
<td>- Shift to primary/community setting</td>
<td></td>
</tr>
<tr>
<td>- Replacement of physical appointments with Skype or telephone clinics</td>
<td></td>
</tr>
<tr>
<td>- Absolute reduction in follow up appointments</td>
<td>5% each</td>
</tr>
</tbody>
</table>

Through this work we will release capacity which will contribute to compliance with national waiting time targets and help the East London health system better cope with growing demand.

\(^{131}\) Transforming Services Changing Lives (2014)
8.5 Investment costs

To implement this change the following investments are required.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital costs (estates / equipment / IT infrastructure)</td>
<td>£0.1m</td>
<td>£0.1m</td>
<td>£0.1m</td>
<td>£0.1m</td>
<td>£0.1m</td>
<td>£0.47m</td>
</tr>
<tr>
<td>Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£1.06m</td>
</tr>
<tr>
<td>Organisational development costs and project management costs</td>
<td>£0.4m</td>
<td>£0.4m</td>
<td></td>
<td></td>
<td></td>
<td>£0.8m</td>
</tr>
</tbody>
</table>

The table below identifies the additional workforce requirements that will be required to enable the change:

<table>
<thead>
<tr>
<th>Workforce requirements</th>
<th>Band (if applicable)</th>
<th>WTE(^{132})</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Trauma and orthopaedics</td>
<td>0.21</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Gynaecology</td>
<td>0.21</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Respiratory medicine</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Cardiology</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Dermatology</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Urology</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - ENT</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - General surgery</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Gastroenterology</td>
<td>0.10</td>
</tr>
<tr>
<td>Specialist advice for GPs (via email/ telephone)</td>
<td>Consultant - Paediatrics</td>
<td>0.10</td>
</tr>
</tbody>
</table>

---

\(^{132}\) Whole Time Equivalent

133
**8.6 Impact on activity and revenue**

**Activity impact**

Our proposed new model of care will result in a 20% reduction in face to face outpatient appointments taking place at Barts Health over the next five years. This is equivalent to a reduction in 184,000.

This releases valuable clinical capacity for:

- hot clinics and other aspects of the acute care hubs model (please see part 3, section 6)
- technology based appointments (Skype, email, telephone)
- working more closely with GP and community services to improve skills and capability.

Change is necessary because without it, there will need to be an additional 141,000 appointments per year by 2020/21.

**Anticipated number of outpatient appointments at without change (in 000’s)**

![Chart showing anticipated number of outpatient appointments at without change](chart.png)
**Financial impact**

After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £64.9m and £82.3m over a five year period dependent on the timescale and extent to which redesigned pathways are established.

New models of provision such as hot clinics (see part 3, section 6) are likely to provide alternative income for Barts Health, though have not been costed as part of this initial appraisal. Further financial validation is needed as part of the development of a full business case.

**8.7 System commercial considerations and transitional support required**

Payment innovation is likely to need to be required to support new models of outpatient provision. This includes ensuring acute, primary care and community providers are adequately compensated for care delivered in innovative ways e.g. Skype clinics, quick access to specialist advice by email or over the phone. A reduction in physical outpatient appointments will reduce estate needs and costs for Barts Health, which would allow the trust to use freed up capacity in a different way.
## 8.8 Delivery risks

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk likelihood</th>
<th>Risk impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of collaboration across East London. Without agreement on delivery architecture and project management resource, work is unlikely to proceed at pace and in alignment</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Implementation plan to be drafted by March 2016</td>
</tr>
<tr>
<td>Lack of resources to take change programme forward across organisational boundaries.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Resource will need to be reviewed in line with a business case submission</td>
</tr>
<tr>
<td>Delivery is unlikely without clear focus and prioritisation.</td>
<td>3</td>
<td></td>
<td>12</td>
<td>A prioritisation process has been built into implementation plan. Clinical Reference Board will need to assist with clinical prioritisation</td>
</tr>
<tr>
<td>Lack of strong leadership could impact delivery of ambitious targets</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>Agree clinical, finance and management leads in both commissioning and provider organisations as part of implementation planning</td>
</tr>
<tr>
<td>Failure to deliver IT requirements to planned timescale</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>Regular contact with IT workstream project manager and East London Chief Information Officer throughout process to date to ensure requirements are fully understood and timeline for implementation plan agreed</td>
</tr>
</tbody>
</table>
| Lack of alignment with integrated care planning approach for high/medium risk patients| 3               | 4           | 12          | Long term conditions redesign will be taken forward as part of the care closer to home programme }
8.9 Next steps

Cross-cutting work and a rolling programme to redesign pathways could begin in 2016.

Given the important of alignment with care planning for ‘high’ and ‘medium’ risk patients, it is proposed that long term conditions redesign is taken forward as part of the Care Closer to Home programme of work.

The diagram below describes the structure of the pathway redesign process, based on the use of proven quality improvement methodologies (Lean and Six Sigma). The redesign phase will be carried out through a redesign workshop involving staff from all relevant organisations as well as patient representatives.

Pathway redesign process

<table>
<thead>
<tr>
<th>Engagement</th>
<th>Diagnostic</th>
<th>Redesign</th>
<th>Test and Refine</th>
<th>Launch</th>
<th>Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Engage operational and clinical leaders</td>
<td>• Analyse key performance indicators</td>
<td>• Review current state and best practice</td>
<td>• Prepare for the trial.</td>
<td>• Engage with broader teams in provider organisations.</td>
<td>• Repeat baseline measurements.</td>
</tr>
<tr>
<td>• Agree roles/responsibilities</td>
<td>• Analyse best practice</td>
<td>• Design future state process using Lean.</td>
<td>• Communicate and engage with relevant teams.</td>
<td>• Implement new way following the plan.</td>
<td>• Develop ongoing improvement plans.</td>
</tr>
<tr>
<td>• Agree business and customer metrics</td>
<td>• Map and evaluate current services</td>
<td>• Understand the supporting flows including information, IT, technology, estates and workforce.</td>
<td>• Run trial using Six Sigma methods.</td>
<td>• Set up monitoring for the key measures.</td>
<td></td>
</tr>
<tr>
<td>• Understand high level process</td>
<td>• Observation and current state mapping</td>
<td>• Agree outcome measures and PMO process.</td>
<td>• Review and refine process from trial.</td>
<td>• Set up process audit.</td>
<td></td>
</tr>
<tr>
<td>• Go and see</td>
<td>• Patient and staff engagement</td>
<td>• Assess risk and benefit.</td>
<td>• Validate benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Share findings and provide opportunity for feedback.</td>
<td>• Develop business case.</td>
<td>• Finalise protocols and other required documents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Design the test and refine phase.</td>
<td>• Agree targets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Create implementation plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Upcoming milestones

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Description</th>
<th>Completion timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resourcing</td>
<td>Agree resources within commissioner and provider organisations to take forward implementation planning</td>
<td>December 2015</td>
</tr>
<tr>
<td>Agree approach to payment innovation</td>
<td>For Skype/telephone clinics</td>
<td>January – March 2016</td>
</tr>
<tr>
<td>DNA reduction workshop</td>
<td>Workshop with provider and commissioning staff to agree improvement plan to reduce DNAs in outlying specialties</td>
<td>February 2016</td>
</tr>
<tr>
<td>Implementation planning</td>
<td>Draft implementation plan including agreement of which pathways will be redesigned first, the</td>
<td>February 2016</td>
</tr>
<tr>
<td>Mobilisation</td>
<td>Set up redesign workshops and pathway improvement working groups</td>
<td>March 2016</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Redesign events</td>
<td>Run first tranche of redesign events that have an East London focus (where appropriate) or borough focus to agree changes to pathways</td>
<td>April - June 16</td>
</tr>
<tr>
<td>Implement agreed changes</td>
<td>N/A</td>
<td>Post redesign events</td>
</tr>
</tbody>
</table>

appointment of clinical leads and undertake the diagnostic stage
9: Reduce unnecessary testing

9.1 The case for change

East London CCGs spent £42.5 million on GP-requested diagnostics in 2014/15: £32m on pathology and £10.5m on imaging. Looking forward, the local demand for pathology and imaging investigations is expected to grow by 10.6% over the next five years.

National evidence\textsuperscript{133} has suggested that up to 25% of pathology diagnostics carried out are unnecessary. Locally, recent audit work at City and Hackney CCG has found 20% of MRI investigations requested by GPs could have been avoided.

Analysis of local data has revealed significant variation in the number of diagnostic investigations requested by GPs in Newham, Tower Hamlets and Waltham Forest: on average, 54% across the top 20 high-cost imaging diagnostics and 32% across the top 20 pathology diagnostics. National benchmarking has revealed some significant local outliers.

Variation in East London GP-requested ultrasound scans. Tests in each CCG (2014/15)

This data suggests that patients are frequently referred for investigations they don’t need. This is having a negative effect on patient experience and placing an unnecessary burden on resources at a time of growing demand and increasing waiting times for key diagnostics.

Inconsistent referral practice also suggests that we are providing inconsistent care. In some cases, patients may not be referred for investigations when they should be – potentially leading to treatment that is more complex and costly later on.

Reducing unnecessary diagnostics and speeding up the diagnostic process will be even more important with the likely introduction of new four-week cancer targets by 2020, which will require 95% of patients are given a diagnosis or the all-clear within 28 days of GP referral.

We know from the Transforming Services Changing Lives Case for Change that poor IT connectivity, overly cautious practice and a lack of consistent guidelines contribute to over-investigation locally. We need to drive up outcomes and save money by:

- taking a systematic approach to ensure that clear referral guidance and robust pathways of care are in place and that these are followed uniformly
- adopting best practice
- ensuring information technology is fully exploited

At a time of growing international interest in maximising the value of healthcare interventions and the harms of over-investigation, we have an opportunity to improve local practice and ensure sustainability of the east London health economy for the next generation. Our aim is simple: to ensure patients receive the investigations they need, when they need them.

### 9.2 Model of care

Over the next three years we plan to undertake a rolling programme of work focusing on the top 20 highest impact in both imaging and pathology diagnostics.

#### Top 20 high impact GP requested pathology diagnostics in East London

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Newham CCG Activity per 1000</th>
<th>Tower Hamlets CCG Activity per 1000</th>
<th>Waltham Forest CCG Activity per 1000</th>
<th>Newham CCG Total spend per 1000</th>
<th>Tower Hamlets CCG Total spend per 1000</th>
<th>Waltham Forest CCG Total spend per 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Blood Count (FBC)</td>
<td>395.299</td>
<td>341.618</td>
<td>353.901</td>
<td>£653,808.24</td>
<td>£550,995.85</td>
<td>£342,403.88</td>
</tr>
<tr>
<td>Mean cell volume</td>
<td>392.302</td>
<td>343.213</td>
<td>355.497</td>
<td>£648,851.73</td>
<td>£553,567.60</td>
<td>£343,947.24</td>
</tr>
<tr>
<td>Platelet count</td>
<td>392.149</td>
<td>341.563</td>
<td>353.732</td>
<td>£648,599.34</td>
<td>£550,906.95</td>
<td>£342,240.08</td>
</tr>
<tr>
<td>Electrolytes, Serum</td>
<td>390.669</td>
<td>331.472</td>
<td>355.444</td>
<td>£546,150.62</td>
<td>£534,831.90</td>
<td>£343,896.28</td>
</tr>
<tr>
<td>Creatinine level, Serum</td>
<td>390.130</td>
<td>331.500</td>
<td>355.801</td>
<td>£645,259.20</td>
<td>£534,676.35</td>
<td>£344,242.08</td>
</tr>
<tr>
<td>Potassium level, Serum</td>
<td>389.630</td>
<td>331.315</td>
<td>355.226</td>
<td>£644,432.22</td>
<td>£534,377.90</td>
<td>£343,685.16</td>
</tr>
<tr>
<td>Albumin level, Serum</td>
<td>382.331</td>
<td>267.390</td>
<td>348.378</td>
<td>£632,360.46</td>
<td>£431,272.95</td>
<td>£337,060.36</td>
</tr>
<tr>
<td>Alkaline phosphatase activity, Serum</td>
<td>380.763</td>
<td>267.232</td>
<td>348.149</td>
<td>£629,766.75</td>
<td>£431,018.95</td>
<td>£336,838.32</td>
</tr>
<tr>
<td>Alanine transaminase activity, Serum</td>
<td>363.468</td>
<td>236.429</td>
<td>325.493</td>
<td>£601,160.76</td>
<td>£381,336.55</td>
<td>£314,918.24</td>
</tr>
<tr>
<td>Bilirubin level, Serum</td>
<td>363.455</td>
<td>236.429</td>
<td>325.493</td>
<td>£601,139.28</td>
<td>£381,336.55</td>
<td>£314,918.24</td>
</tr>
<tr>
<td>Cholesterol level, Serum</td>
<td>298.779</td>
<td>245.201</td>
<td>265.816</td>
<td>£494,168.88</td>
<td>£395,484.35</td>
<td>£257,180.56</td>
</tr>
<tr>
<td>Haemoglobin A1c level, Whole blood</td>
<td>260.247</td>
<td>299.661</td>
<td>153.228</td>
<td>£430,437.72</td>
<td>£483,323.90</td>
<td>£148,249.92</td>
</tr>
<tr>
<td>TSH level, Serum</td>
<td>267.919</td>
<td>209.831</td>
<td>261.140</td>
<td>£443,127.03</td>
<td>£338,435.95</td>
<td>£252,656.04</td>
</tr>
<tr>
<td>HDL cholesterol, Serum</td>
<td>298.117</td>
<td>169.516</td>
<td>264.443</td>
<td>£493,073.40</td>
<td>£273,411.95</td>
<td>£255,851.96</td>
</tr>
<tr>
<td>Free T4 level, Serum</td>
<td>268.136</td>
<td>209.866</td>
<td>214.466</td>
<td>£443,486.82</td>
<td>£338,493.10</td>
<td>£207,498.20</td>
</tr>
<tr>
<td>Urea level, Serum</td>
<td>7.532</td>
<td>331.469</td>
<td>355.455</td>
<td>£12,458.40</td>
<td>£534,625.55</td>
<td>£343,907.20</td>
</tr>
<tr>
<td>Triglycerides level, Serum</td>
<td>297.984</td>
<td>67.957</td>
<td>264.281</td>
<td>£492,853.23</td>
<td>£109,607.35</td>
<td>£255,696.44</td>
</tr>
<tr>
<td>Chloride level, Serum</td>
<td>1.877</td>
<td>331.307</td>
<td>244.357</td>
<td>£3,103.86</td>
<td>£534,365.20</td>
<td>£236,418.00</td>
</tr>
<tr>
<td>Protein level, Serum</td>
<td>4.071</td>
<td>240.331</td>
<td>327.175</td>
<td>£6,733.98</td>
<td>£387,629.40</td>
<td>£136,545.32</td>
</tr>
<tr>
<td>Ferritin level, Serum</td>
<td>165.435</td>
<td>183.059</td>
<td>64.609</td>
<td>£273,622.98</td>
<td>£295,255.95</td>
<td>£62,509.72</td>
</tr>
</tbody>
</table>

Building on work undertaken by clinicians and management over the past six months to identify initial key lines of enquiry, we plan to undertake a clinically-led programme of work.

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134 The most costly to the system as calculated by volume x unit cost, 2014/15
focusing on the top twenty highest impact imaging and pathology diagnostics in terms of volume and cost. We will:

- standardise our approach and roll out clear referral guidance across east London
- continue to engage with clinical teams and management to explore, understand and challenge variation and target outliers
- bring together clinicians from across primary and secondary care to identify opportunities to introduce best practice and share local good practice
- consider moving to ‘direct access’ for selected imaging diagnostics, enabling GPs to refer patients straight to test before they see a hospital specialist (taken forward by the TST pathway redesign workstream)
- challenge behaviour and support GPs to reduce defensive practice
- improve IT connectivity to provide clinicians better access to test results, providing a clear view of the diagnostic pathway and reducing duplicate investigations (image reports into health information exchange, unification of hospital imaging systems)
- implement electronic GP requesting for imaging diagnostics
- customise IT systems to give GPs more control over the tests they request
- implement ‘pop-up’ notifications to help enforce referral guidance (e.g. to ensure minimum testing intervals are adhered to) and provide supportive guidance for GPs (e.g. best practice / investigation cost).

Approach and phasing
There are four planned phases to this programme of work.

Summary of planned phasing for programme of work
Phase 1 (2016/17)

- Quick wins and progression of work based on engagement and analysis (see below)
- Further focused analysis and engagement to target variation and review guidance and pathways
- Implementation of initial IT customisation. Radiology reports uploaded into Cerner Health Information Exchange, enabling improved sight of the diagnostic pathway for GPs. Electronic requesting for imaging diagnostics rolled out to GPs across WEL, enabling transition away from paper-based requesting.

✔ Target outcome by Q4 16/17: 5% activity reduction across top 20 GP-generated pathology and imaging diagnostics against 2014/15 baseline

Example outputs from clinical workshop in August focusing on pathology

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>Clinical hypothesis or discussion point</th>
<th>Consensus</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting glucose</td>
<td>Should we stop testing fasting glucose for the vast majority of patients?</td>
<td>Unnecessary to test both. HbA1c preferable. However need to be clear when HbA1c not applicable (e.g. type 1 diabetes).</td>
<td>Proceed but need to clearly define exceptions. Education will be key to successful implementation.</td>
</tr>
<tr>
<td>T3</td>
<td>Remove from T-Quest?</td>
<td>T3 should not be requested by GPs: laboratory only</td>
<td>Proceed to remove option from T-Quest.</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>Could we stop testing for Vitamin D deficiency where it is suspected in high risk groups and simply begin treatment instead?</td>
<td>Clearly an area for more work as potentially large gains to be made particularly in view of local demographic</td>
<td>However more work needed to understand clinical impacts. Review CEG guidance.</td>
</tr>
<tr>
<td>LFT vs ALT</td>
<td>Should we simply check ALT rather than a full LFT panel unless there is clinical suspicion?</td>
<td>More thinking needed.</td>
<td>Proceed to review diagnostic pathways for liver (i.e. statin NICE guidance is to test at 3 and 12 months). Split off on T-Quest and confirm guidance for different conditions.</td>
</tr>
<tr>
<td>GGT</td>
<td>Where GGT is automatically tested as part of an LFT test, should this be stopped?</td>
<td>Yes – take out of standard full panel.</td>
<td>Proceed – remove from GP standard panel. Leave as separate option.</td>
</tr>
<tr>
<td>ESR vs CRP</td>
<td>Should we abandon ESR except for very specific conditions?</td>
<td>Over used and very non specific test. Stop doing (except in limited circumstances such as Giant Cell Arteritis) and use CRP instead.</td>
<td>Proceed to communicate with clinicians about avoiding ESR except in specific circumstances and to suggest the use of CRP instead. May need to liaise with rheumatology in addition to those consulted.</td>
</tr>
<tr>
<td>Urea</td>
<td>Should we stop testing urea (as a part of a routine ‘U&amp;Es’ panel) via direct access unless very specifically requested?</td>
<td>Yes – but would need robust systems in place to catch exceptions.</td>
<td>Proceed but exceptions must be clearly identified. Value in considering cost and impact of this. Link with development of CKD clinics in the community.</td>
</tr>
</tbody>
</table>
Phase 2 (2017/18)
- Continued work to target variation and review guidance and pathways
- Increased GP uptake of electronic requesting functionality
- Further implementation and roll out of IT customisation
- Further behaviour change work.

✓ Target outcome by end Q4 17/18: cumulative 10% activity reduction across target top 20 GP-generated pathology and imaging diagnostics against 2014/15 baseline

Phase 3 (2018/19)
- Complete work to target variation across high impact areas
- Further IT customisation and adoption.

✓ Target outcome by end Q4 18/19: cumulative 15% activity reduction across target top 20 GP-generated pathology and imaging diagnostics against 2014/15 baseline

Phase 4 (2019/20):
Further benefits realisation.
✓ Target outcome by Q4 19/20: cumulative 20% activity reduction across top 20 GP-generated pathology and imaging diagnostics against 2014/15 baseline

Crossover with TST pathway redesign workstream
When secondary care referral is required, we will develop ‘straight to test’ pathways allowing primary and community practitioners to request tests for patients in advance of consultation with a hospital specialist. This will reduce delays to diagnosis and treatment planning and ensure specialist appointments always add value. Clear referral guidelines and monitoring mechanisms will mitigate the potential risk of over-testing due to ease of access. A review of selected musculoskeletal (MSK), computerised tomography (CT) and ultrasound pathways identified at clinical workshops in 2015 is being taken forward by the TST pathway redesign workstream.

Collaboration across the system
Collaboration across primary and secondary care and across organisations has been central to the development of this work and will be crucial to achieving the planned impact of this scheme.

Workshops to test clinical hypotheses on variation and to develop key lines of enquiry have so far brought together nominated clinical representatives from Newham, Tower Hamlets and Waltham Forest, hospital consultants representing key specialties, senior management from Barts Health and key IT stakeholders representing primary and secondary care.

To provide support and oversight at implementation stage we intend to set up a regular working group with similar representation, plus key contracting and other CCG stakeholders.
A new GP symposium, organised by Barts Health and bringing together a large group of primary and secondary care clinicians, will help to support some of the wider ambitions of this programme of work (e.g. behaviour change). Both the interface group and symposium will provide vital access to GP networks across WEL.

9.3 Engagement

The following key stakeholders have been engaged to help shape these proposals

- Nominated GP clinical leads for East London
- East London CCG chief officers
- Barts Health: Clinical Director of Haematology; Clinical Director of Imaging; Director of Pathology; Director of Imaging Chief Information Officer; Deputy Director of IT; Clinical leads for imaging; Clinical Support Service CAG Director
- Acute specialists: biochemistry, haematology, liver, endocrinology, renal, virology
- TST GP clinical lead (City & Hackney CCG)
- Barts Health Pathology IT Manager
- East London Chief Information Officer

We have also engaged with stakeholder groups

- TST Clinical Reference Group
- WEL Clinical Strategy Group
- TST Workstream Executive
- Clinical Support Services Clinical Academic Group – Barts Health
- TST Board

Workshops:

- Diagnostics workshop: 13 January 2015. Chaired by the Clinical Director of Imaging for Barts Health and Newham CCG TST representative. Attended by 20 senior clinicians and managers from Barts Health and WEL CCGs.
- Barts Health / East London CCG informatics workshop: 9 February 2015. Chaired by Newham CCG TST representative. Attended by GPs from East London CCGs; Barts Health pathology IT service manager; Barts Health Chief Information Officer; East London Chief Information Officer; and Deputy Director of IT for Barts Health.
- Pathology protocols workshop: 8 August 2015. Chaired by Newham CCG TST representative. Attended by Barts Health consultants representing key specialties; GPs and clinical leads from East London CCGs and City and Hackney CCG.
- Imaging protocols workshop: 15 August 2015. Chaired by the Clinical Director of Imaging. Attended by eight clinical leads from Barts Health.
9.4 Outcomes the change will achieve

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Metric by 2020/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in activity across top 20 high-cost GP-generated pathology diagnostics</td>
<td>20%</td>
</tr>
<tr>
<td>Reduction in activity across top 20 high-cost GP-generated imaging diagnostics</td>
<td>20%</td>
</tr>
</tbody>
</table>

9.5 Investment costs:
In order to implement the model of care the following investment is required. This includes project implementation costs, organisational development (OD) costs and investments in IT.

*Phased investment costs over five years*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>£0.2m</td>
<td>£0.2m</td>
<td>£0.1m</td>
<td></td>
<td></td>
<td>£0.5m</td>
</tr>
<tr>
<td>Organisational</td>
<td>£0.12m</td>
<td>£0.12m</td>
<td>£0.02m</td>
<td></td>
<td></td>
<td>£0.26m</td>
</tr>
<tr>
<td>development costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.6 Impact on activity and revenue including sensitivity analysis
The proposed model of care seeks to reduce activity, resulting in a recurring 20% reduction of the top 20 high-impact GP-requested pathology and imaging diagnostics by 2019/20. This equates to 3.3 million fewer tests over five years.

*Anticipated reduction in GP-requested diagnostic activity over five years*

<table>
<thead>
<tr>
<th></th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
<th>19/20</th>
<th>20/21</th>
<th>Total 5 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging</td>
<td>-4,791</td>
<td>-9,581</td>
<td>-14,372</td>
<td>-19,162</td>
<td>-19,162</td>
<td>-67,067</td>
</tr>
<tr>
<td>Pathology</td>
<td>-233,762</td>
<td>-467,524</td>
<td>-701,286</td>
<td>-935,048</td>
<td>-935,048</td>
<td>-3,272,669</td>
</tr>
<tr>
<td>Imaging and pathology</td>
<td>-238,553</td>
<td>-477,105</td>
<td>-715,658</td>
<td>-954,210</td>
<td>-954,210</td>
<td>-3,339,736</td>
</tr>
</tbody>
</table>
After conducting financial impact analysis, we undertook sensitivity analysis which suggests a net saving of between £20.7m to £25.5m over a five year period. This net position takes account of investment costs of the £0.8m investment costs which are detailed above. IT investment costs have been excluded as these have been factored into the IT focused initiatives within this programme.

### Potential reduction in spend on GP-requested diagnostics over five years

<table>
<thead>
<tr>
<th>Year</th>
<th>Imaging</th>
<th>Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/17</td>
<td>£1,000,000</td>
<td>£2,000,000</td>
</tr>
<tr>
<td>17/18</td>
<td>£2,000,000</td>
<td>£3,000,000</td>
</tr>
<tr>
<td>18/19</td>
<td>£3,000,000</td>
<td>£4,000,000</td>
</tr>
<tr>
<td>19/20</td>
<td>£4,000,000</td>
<td>£5,000,000</td>
</tr>
<tr>
<td>20/21</td>
<td>£5,000,000</td>
<td>£6,000,000</td>
</tr>
</tbody>
</table>

#### 9.7 Delivery risks

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay to implementation of supporting IT functionality will reduce the impact of this scheme.</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>Regular contact with IT workstream project manager and WEL Chief Information Officer throughout process to date. Requirements and fully understood and timelines confirmed.</td>
</tr>
<tr>
<td>Failure to gain necessary traction (i.e. buy-in and time of key stakeholders) would slow progress and reduce the overall impact of this scheme.</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>Working with CCGs and other key stakeholders to identify nominated clinical and non-clinical leads to drive planning and delivery stage to time, scale and standard. Initiative sits within Care Closer to Home governance arrangements ensuring senior leadership and accountability. Barts Clinical Support Services Clinical Academic Group and WEL</td>
</tr>
</tbody>
</table>
Clinical Strategy Group engaged early in 2015.

9.8 Next steps

Work can progress as soon as funding approved. Key next steps are as follows:

<table>
<thead>
<tr>
<th>Immediate next steps</th>
<th>Action outline</th>
<th>Timescales</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Business case for funding to progress with phase one of work and subsequent phasing as detailed above</td>
<td>Work with clinical leads to develop detailed business case for March 2016 in line with programme timescale</td>
<td>March 2016</td>
</tr>
<tr>
<td>• Phase one to commence subject to business case approval</td>
<td>Work to implement changes for quick win areas and commencement of rolling programme to target variation. Detailed phasing</td>
<td>April 2016</td>
</tr>
</tbody>
</table>

Project management resource has been planned to work through areas identified by workshops in 2015. Some of these will be quick wins while others require further analysis and engagement.

Concurrently, systematic work will commence immediately at phase one to continue to target variation across high impact diagnostics and undertake further engagement and analysis to define the streams of work required to tackle variation. High level milestones for the programme of work are set out below.

High level milestones for programme of work

- 2015: External: CCG/provider interface working group and GP symposium
- 2016: OD: support backfill costs to achieve primary care and GP representation and engagement
- 2017: Progress quick wins identified through clinical workshops
- 2018: Commence rolling programme of work to engage with clinical teams, understand variation and target outliers across high impact areas
- 2019: Pathway redesign: linked work to review pathways for selected MSK, CT and US
- 2020: IT: supporting connectivity improvement work, introduction of GP image-requesting
- 2021: IT: customisation to enable/enforce protocols and supporting pop-up notifications, OD: engagement to support introduction of electronic image requesting and move away from paper, identify early adopters and champions, train the trainer
- Continued benefits realisation
- Target 20% impact across high impact areas
10: Deliver shared care records across organisations

10.1 The case for change

There is a need to make significant changes to the current health system in East London in order to deliver safe, sustainable and effective care. To support these new models of care, information needs to be able to flow more effectively between different health and social care providers.

The development of a shared electronic care record is central to this approach and can help to improve:

- patient safety – supporting safer and more informed treatment by providing clinicians with timely access to accurate and up-to-date information
- efficiency – reducing the time, effort and resources required to obtain relevant information regarding patient care
- effectiveness – supporting the delivery of appropriate care to patients
- patient experience – reducing the need for patients to recall or repeat their medication information and supporting people with difficulties communicating.

There has already been significant progress across East London and the foundations of a resilient, flexible, health IT infrastructure have been established. The standards of the individual systems used by each health and social care provider have advanced and there is now a strong base to develop an interconnected system.

However, there is much work to do to ensure that every patient and their care providers can:

- access a complete view of the shared care records they need, in an electronic format, when and where they need it
- ensure that care provided across the system is fully integrated, well-coordinated and convenient for patients
- support a transition to care away from acute centres and into the community.

Broad adoption of a shared care record across East London will require health information to be easily and appropriately shared to support multiple uses across a wide range of health IT solutions which are well imbedded in the health economy.

Work has already been done by the East London community of CCGs together with their provider organisations – including Barts Health NHS Trust, East London NHS Foundation Trust (ELFT), North East London NHS Foundation Trust (NELFT) and local authorities – to deliver a shared view of patients’ health records using the Cerner’s health information exchange (HIE135) in conjunction with Healthcare Gateway’s Medical Interoperability Gateway (MIG). MIG has been developed to share GP and hospital electronic health records from EMIS (the leading provider of primary care systems) and Cerner. It is visible to all clinicians with proper access and consent. HIE/MIG is now being extended to include other healthcare software providers used locally, including ELFT’s Serverlec Healthcare’s RiO and the Newham social care system, AzeusCare.

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135 Cerner HIE is part of the Cerner Millennium solutions which enables the interconnection of health systems through open messaging standards to allow the sharing of electronic health records.
Without continued work, however, MIG/HIE will remain as a limited, read only view which is not connected to any neighbouring providers or across the rest of London. In read only form, HIE/MIG shared care records could not be used for the systematic review and risk analysis required to support population health and integrated care.

Without the delivery of a two-way, bookable service, the objectives detailed in the urgent care workstream (see part 3, section 2 for more detail) - such as the need to operate across primary and community providers in a more joined up fashion - would also not be possible.

We are also aware that some clinicians are not utilising the existing shared view of health records during consultations with patients. Increasing usage by clinicians would reduce the risk inherent in the provision of emergency care medicine by enabling clinicians to be aware of any allergies, current medication and other health alerts.

The delivery of a structured shared care records has to be delivered to address the needs of the local health economy and to deal with an increasing population and a desire to deliver better, more personal care and improved patient outcomes (including living longer and living healthier) at lower cost.

East London is not operating in isolation. The case for change is being driven not just locally but nationally. NHS England has developed a digital strategy that each CCG is required to emulate and report against to enhance the move towards a paperless working environment and more interoperable IT systems. At a national level the focus is on how systems should interconnect and the standards that need to be adopted to support this.

At a London level, the Healthy London Partnership has created a programme of work which focuses on connecting Londoners and health and care providers to allow for real time access to records and information. According to its vision:

_This will be achieved by establishing interoperability standards that allow services provides to seamlessly exchange information across a diverse systems landscape. We will develop universal services such as ‘consent’, ‘identify management’ and ‘role-based access controls’ allowing service providers to overcome common issues that have historically acted as a barrier to true interoperability_.136

NHS England (London) is also working with individual CCGs to define how they can link together to share information outside of their local infrastructure. CCGs in East London will need to be part of this wider delivery in order to deliver the full benefits of shared care records for their own patients.

### 10.2 Model of care

Sharing care records and vital information across East London health and social care organisations will be crucial to improving outcomes, reducing waste and improving patients’ experience of care.

As described above, there is work already underway across East London which contributes to the delivery of a shared electronic health record. The integration between Cerner Millennium and EMIS, for example, has delivered proven integration and secure connectivity and has successfully delivered the following functionality:

- A GP record summary containing 10 pages of patient data is available to Barts Health clinicians, including real-time medications, current conditions, allergies and

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136 [https://www.myhealth.london.nhs.uk/healthy-london](https://www.myhealth.london.nhs.uk/healthy-london)
alerts. This is presented by MIG/HIE as a page within Cerner Millennium with tabs for each section of the record

- Future appointments and discharge summaries for Barts Health patients are viewable by GPs.
- System integration and patient matching between primary and secondary care for practices using EMIS.
- Approval and sign-up to data sharing for the majority of GPs across Tower Hamlets, Waltham Forest and Newham, the exception being the GPs using the healthcare system TPP SystmOne.
- The electronic transition of discharge summaries and other communications through the BT Spine using Data Transfer Service (DTS), a collection of national applications, services and directories, replacing post and fax.

We are planning on further expanding the current functionality in East London in two ways. Firstly, we will increase the usage and adoption of what has already been delivered. This work will be centred on the training of GPs and hospital clinicians so that fewer paper discharges are produced and more use is made of the DTS functionality. We will also focus on better communicating the availability of the patient records view so that more clinicians make use of this visibility during patient consultations.

Secondly, we plan to expand the integration of our systems so that electronic health records can be shared between more health and social care providers. This planned work is shown below.

**Roadmap for interoperability for East London**
This plan allows for:

- sharing of structured data between GPs and the acute care setting. This data can be retained and reused or included into reporting information sources
- integrating urgent care systems such that clinical staff within the Urgent Care services who have the correct permissions and consent from the patient can initially view the electronic health record, but within two years provide a bookable, two way service between NHS 111, urgent care, out of hospital services and GP systems
- providing further integration for Order Communications (the process for electronic ordering of pathology and radiology tests and the electronic distribution of test results)
- integration of community and mental health systems for ELFT and NELFT allowing electronic health records to include these critical components of patients’ health and social care record
- expanding the range of information available to include the care plan and crisis plans where required.

Current there is no agreed approach for the integration of Waltham Forest and Tower Hamlets social care systems and work will continue to develop a strategy to determine the feasibility and mechanism for this if supported by the two boroughs.

We will also continue to work with NHS England, which will be defining the standards for interoperability and developing a solution for sharing of patient health and social care information at London and national levels. The standards and plans for this are being developed now and East London is taking an active part in developing the strategy for an interoperable system solution for London.

**How clinicians will work differently in the future**

With the delivery of enhanced interoperability, clinicians and social care workers will have access to patient records whenever they are in contact with a patient, this record will contain all the elements which are relevant to the user and which have been agreed to be shared. Access to this detailed information will mean that diagnosis and treatment are able to be delivered more efficiently and with reduced risk. This improves care for the patient and reduces the cost of delivery of the service.

The electronic shared care record will also enhance risk stratification and enable this to take place in real time (currently this is a monthly process), which supports the development of care plans and helps keep the most at-risk patients out of acute care for as long as possible.

**Addressing the case for change**

These changes help deliver the end state described in the case for change document, set for us by national, regional and local strategies for interoperability. The integration roadmap for shared care records, shown one the previous page, will deliver an end-to-end view of the patient across most care settings, helping to improve the health of the local population and individual patient care.
How the new care model will look and feel for service users

In each health and social care system there will be a new view available to display the shared care record information. If a patient has given their consent, their shared care record can be viewed and eventually edited by clinicians. Patients will also be able to book appointments online. The information available within this new view will be the complete record for the patient, restricted only by elements which have been specifically coded for exclusion.

Timeline

The interoperability work to deliver a shared electronic care record has already started and the plan for the next two to three years is shown above.

10.3 Other significant change initiatives not costed here

Infrastructure review

The organisations across East London have a variable infrastructure base which reflects their legacy and history, support model and current levels of use. IT support is provided across organisations by NEL CSU. However, this is not a consistent model for all areas. Secondary care, community, mental health and social services add to the diversity mix.

Before we can successfully deliver a new model for population health we must first fix the basics across our existing IT infrastructure in terms of people, processes, support and equipment. As a starting point, we must build a clear understanding of the current situation by establishing a clear baseline position. We will do this by conducting an infrastructure review which will identify the key features of the established base. This review will include:

- Hardware
- Service Support
- Qualification of staff
- Service level agreements (SLAs) and monitoring
- Service desk support
- Disaster recovery
- Storage
- Network
- Training
- Applications
- Information governance
- Data quality
- Connectivity
Once we have established the baseline position we will review this against our overall informatics strategy to identify gaps where we can improve the IT infrastructure. This work has commenced, with the initial investigation reporting produced.

We need to grow the pockets of fledgling capability and move to a single, real time, analytics service that will support East London through the introduction of a single platform. This will build on existing functionality or look at delivering a new service. As the new care delivery organisations described in the *Five Year Forward View*137 become established, the provider landscape will change very rapidly and we need to engage with our existing suppliers in order to understand current and future plans. This will allow us to reach an informed decision based on consultation. There will be a cost associated with this new technology against which the benefits to the service in East London will need to be carefully assessed.

**Advanced informatics**

There are pockets of analytical work taking place across East London, for example the analysis of EMIS data by the Clinical Effectiveness Group for Tower Hamlets and Newham and the use of the Health Analytics138 solution in Waltham Forest. These projects provide local level analysis and population stratification to support the development of targeted care plans for the highest risk segments of the population.

**Patients’ involvement with their own electronic health record**

The service design clearly needs to take account of the patient view of population health and how integrated care is delivered.

How patients want to interact with their data, the consent models they wish us to adopt and the level of information sharing that we make available will provide an invaluable guide to the delivery of population health informatics. We need to consult with our patients to understand this. The model being developed is based on the delivery of patient and service information through available apps.

**10.4 Engagement**

The focus of engagement has been with IT leads in commissioners, providers and local authorities in Newham, Tower Hamlets and Waltham Forest, and with CCGs in surrounding areas (City and Hackney, and BHR).

- Informatics programme board and steering group monthly meetings, invitees for both include: IT leads from commissioners (Newham; Tower Hamlets; Waltham Forest; City and Hackney; and BHR CCGs) and providers (Barts Health, Homerton, ELFT and NELFT). IT leads from Newham, Tower Hamlets and Waltham Forest local authorities were also invited. IT leads from Department of Health and UCLP were invited to the programme board.

- Regular attendance at Newham, Tower Hamlets and Waltham Forest CCG informatics forums. Invitees include local GPs

- Regular meetings with IT leads from NHS England (London)

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138 [http://www.health-analytics.co.uk/](http://www.health-analytics.co.uk/)
• Shared care records workshop on 14 May 2015. Attended by 65 members of patients and the public from Newham, Tower Hamlets and Waltham Forest. Invitees sought via CCG patient involvement teams, local Healthwatch organisations, CVS and press releases


10.5 Outcomes the change will achieve

The delivery of interoperability and a shared electronic health record will not in itself deliver benefits to the system. However, it will enable the changes in service delivery models across primary, community and acute services, which will in turn transform the provision of care across East London. Some benefits which can be attributed directly to the provision of shared care records are shown in the table below.

<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination of paper from the system</td>
<td>95% elimination of orders and requests for radiology and pathology</td>
</tr>
<tr>
<td>Care plans available to all clinicians at the point of need</td>
<td>Electronic presentation of patient care plans at the point of need</td>
</tr>
<tr>
<td>Shared care record available to all clinicians at the point of need</td>
<td>All areas of the service have access to full electronic health record</td>
</tr>
</tbody>
</table>

10.6 Investment costs including sensitivity analysis

In order to implement the model of care the following investments are required.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital charges</td>
<td>£2.0m</td>
<td>£2.0m</td>
<td>£2.0m</td>
<td>£2.0m</td>
<td>£2.0m</td>
<td>£10m</td>
</tr>
<tr>
<td>Revenue costs</td>
<td>£0.2m</td>
<td>£0.75m</td>
<td>£0.68m</td>
<td>£0.23m</td>
<td>£0.09m</td>
<td>£1.95m</td>
</tr>
</tbody>
</table>

Following financial impact assessments we have conducted sensitivity analysis which suggests a likely net cost of between £11.1m - £12.3m.
Impact on activity and revenue

The shared care record will ensure that the models of care defined in TST can facilitate patient shifts. For example, the acute care hub model of care will be underpinned by the use of a patient shared care record, ensuring care closer to home is able to take place.

An example of this is shown in more detail below:

‘Peter has swelling, pain and swelling in his left leg and the skin is red and warm to the touch, and he accesses his local emergency department as a walk-in. He is registered on arrival to the department and is directed for triage by a consultant as part of the Rapid Access Triage service. Based on his symptoms, the consultant suspects he may have deep vein thrombosis.

Peter’s case is discussed by the emergency department and acute medical consultants. Peter is mobile and alert, scores well on the National Early Warning Score (NEWS)139 scale. Checks on his shared record establishes there are no underlying comorbidities or packages of care delivered at home that would necessitate an admission to hospital at this stage. He is referred for focused diagnostic and intervention in the ambulatory care unit.

Blood and urine samples are taken and sent for analysis. Results are stored within the shared record and are accessible to all clinicians with access to this level of patient detail. D-dimer results140 indicate that clots may be present in the vein and an ultrasound scan is carried out in the ambulatory care unit. The result confirms detection of a clot. Peter’s shared record is updated with the test results and ultrasound outputs.

Anticoagulation is prescribed by intravenous infusion on a five day course. Through consultation with Peter and checking of his shared record the clinicians are confident that he can receive his heparin intravenously on site in the unit and return for the next five days to receive his daily infusion, rather than be admitted to the ward. Hot clinic appointments are made for Peter and he is registered on the unit’s patient administration system. All of these details are made available via his shared care record. Peter has a dose of heparin delivered intravenously in the unit before he is discharged home to return the following day for his second dose.

A summary of Peter’s visit to the hospital is visible via his emergency department attendance card and the ambulatory care unit’s clinical team. This information is made available to the patient’s GP and is also permanently available via the record should Peter attend again at a later date.’

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139 https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news
140 A specialised blood test known as the D-dimer test is used to detect pieces of blood clot that have been broken down and are loose in your bloodstream. The larger the number of fragments found, the more likely it is that you have a blood clot in your vein.
10.8 Delivery risks

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk Likelihood</th>
<th>Risk Impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>Develop business case for individual projects and seek funding through TST and informatics channels</td>
</tr>
</tbody>
</table>

There is a risk that the cost of delivery cannot be met through existing funding and thus the work to deliver a shared electronic health record cannot be progressed in the timeline defined.

10.9 Next steps

<table>
<thead>
<tr>
<th>Action</th>
<th>Proposed timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete individual business cases for system changes delivering shared electronic health records</td>
<td>Start of Q4 2015/16</td>
</tr>
<tr>
<td>Confirm funding for individual projects</td>
<td>Mid Q4 2015/16</td>
</tr>
<tr>
<td>Schedule integration work with development team and complete detailed planning</td>
<td>Q4 2015/16</td>
</tr>
<tr>
<td>Commence work on new projects</td>
<td>Q1 2016/17</td>
</tr>
</tbody>
</table>

Newham, Tower Hamlets and Waltham Forest CCGs need to work together to confirm the road map for next year and secure funding for the planned delivery activity through the development of a robust business case.

They will also continue to work with NHS England London and NHS England to help define the standards for information exchange and to develop a regional sharing model for London.
11: Explore the opportunity that Physician Associates may bring

11.1 What are Physician Associates?

The UK’s Competence and Curriculum Framework for the Physician Associate (2012) describes a Physician Associate (PA) as a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.

After the completion of an honours degree in a science or health related discipline and a 2 year PA Postgraduate Diploma programme PAs will be able to undertake the following tasks across all healthcare sectors whilst under supervision:

- formulate and document a detailed differential diagnosis on completion of a history and physical examination
- work with patients and, where appropriate, carers to agree a comprehensive management plan in light of the individual characteristics, background and circumstances of the patient
- maintain and deliver clinical management in collaboration with the patient and on behalf of the supervising physician whilst the patient travels through a complete episode of care
- perform diagnostic and therapeutic procedures and prescribe medications (subject to the necessary legislation)
- request and interpret diagnostic studies and undertake patient education, counselling and health promotion.

11.2 The case for change

As set out in the Strategy and Investment Case (part 2, chapter 2.3), the East London area faces a serious shortfall of GPs in the future (the area will need an extra 125 GPs in five years’ time and 195 in ten years’ time in addition to today’s GP workforce if we don’t change the way we work to deliver forecasted demand), due to an increase in primary care demand and high projected retirement rates in the existing workforce. This is against a backdrop of a national shortage of GPs.

One of the solutions to this problem is the establishment of a flexible workforce which can contribute to multiple specialties across various patient pathways spanning secondary, primary care and social care.

For these reasons (and to create a responsive and safe model of patient care) local primary, secondary, and social care providers may wish to employ PAs who work across all healthcare sectors and a number of patient pathways. They can be used to improve the patient experience and to strengthen multi-professional teams. In addition it is intended that PAs will improve the overall flexibility of our workforce through improving the skill mix. PAs will always work under the supervision of a doctor who will appropriately support them.

There is growing evidence that the introduction of PAs will deliver benefits across a range of areas:
1. **Improved quality of care**
   - Greater continuity of patient care across the whole patient pathway when PAs work across healthcare sectors
   - A primary care workforce which can support the ageing medical workforce and adapt to new ways of working including co-ordinated care and reducing unplanned admissions.

2. **Reduced cost**
   - A reduction in the frequency of use and cost of locum cover, coupled with the fact that introducing PAs is a cost effective solution when other professionals are difficult to recruit such as GPs or Advanced Nurse Practitioners (ANPs). This will result in a more efficient use of trust and practice funds to support the rest of the clinical workforce.
   - There is a broader recruitment pool from which to pick candidates, giving the NHS a broader of choice of skills and experience.

3. **Ability to span traditional divides in the health system**
   - PAs have a holistic/generalist perspective and they provide flexibility, with the potential to work across all healthcare settings and specialties including primary care, secondary acute and mental health care and in some social care environments.

4. **Capacity release for training and development of other staff**
   - PAs can free up time for trained doctors to provide training to others and provide backfill of clinical workforce to attend training. This also makes it easier to maintain patient care and patient safety given the loss of clinical workforce through sickness and absence.

5. **Support the East London system in meeting service standards**
   - By complementing the work of GPs and ANPs and as a result, releasing their capacity to deliver care, East London organisations will be supported in meeting the European Working Time Directive and ‘seven day services’ requirements.

In addition to these benefits, recent workforce reviews by both the Centre for Workforce Intelligence and the Department of Health-commissioned GP Taskforce (which investigated the current and future GP workforce) have recommended investigating or piloting the use of Physician Associates. In a 2002 BMJ study, 83% of NHS clinicians and service respondents supported the introduction of PAs\textsuperscript{141}.

### 11.3 Is there NHS specific evidence for the use of PAs?

Despite relatively little published evidence in the UK, there are a number of case studies:

- Researchers from Kingston University and St George’s University of London reviewed 12 GP practices in England, six of which employed PAs. After controlling for patient age they found that ‘rates of re-consultation after the initial consultation were similar for the physician associates and GPs, as were rates of diagnostic test

\textsuperscript{141} Can physician assistants be effective in the UK? RCP Journal. 2005
orders, referrals and prescriptions’. Patient satisfaction was the same between the two groups and although PAs took longer for appointments, the average cost of an appointment was £6 less for the PA cohort\textsuperscript{142}.

- A cohort of PAs was employed in primary care in Sandwell. The PAs ‘were reported to have made a positive impact on the workload carried out by other members of the practice teams and to have contributed to improvements in access for patients to primary care service’\textsuperscript{143}.

11.4 Where can PAs be used?

Whilst most current PAs in England work in a single organisation (e.g. general practice or acute care NHS trusts) there is potential to consider using them shared across the following settings in combination to accommodate common patient pathways – community, mental health, primary care, acute care, social care.

Where are PAs currently used in East London?

At present only one practice in the East London region employs a PA and three are employed in secondary care. Our research found that each of the current PAs has a very different role and set of responsibilities. As a result of this, the size of the opportunity that comes with introducing and embedding this role is significant.

What is the supply situation?

In terms of supply of the PA workforce, there are now 20 universities in England that are delivering, or intending to deliver, diploma and masters courses by the next academic year – so the level of supply will increase year on year. The UK and Ireland Board of PA Education is forecasting as many as 400 PA diploma graduates by the 2017/18 academic year

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\textsuperscript{142} British Journal of General Practice. 2014

\textsuperscript{143} Can physician assistants be effective in the UK? RCP Journal. 2005
What and where is the future demand for PAs across East London?

The TST project has identified the following need for PAs across the various workstreams:

- **Primary care:** Forecast modelling based on the likely supply projections has shown a need for **27 PAs in five years and 38 in ten years’ time.**
- **Secondary Care:** Based on initially filling 10% of the shortfall in medical roles at Barts Health (the gap between establishment and staff in post), increasing by 20% a year. This would amount **to nine PAs in the first year, increasing to 47 in ten years’ time.**

11.5 What is the likely return on investment?

Although it is difficult to put a cost on improved service quality and patient experience, we can calculate a broad return on investment for PAs in terms of the roles that they can complement. A review of PA productivity in 2000 found that in a mature health and social care system where the role of PAs is well embedded within care models[^144]:

- a PA can perform a large proportion of a doctor’s tasks at a reduced cost (as identified by Drennan et al in June 2014[^145])
- a PA can safely assume at least 83% of primary care visits without direct physician supervision
- cost-benefit analyses of PA-delivered primary care suggest the use of resources is less than physicians, under comparable circumstances

In addition to complementing the current GPs’ and ANPs’ skills, introducing the role of PAs will help to sustain high quality care and patient experience when the recruitment of traditional roles (such as GPs, specialist consultants or nursing staff) is not possible due to national and regional shortages.

Using these assumptions and figures together with our projected demand and annual salary information we can calculate an estimated financial saving from using PAs compared to GPs and acute doctors. Using these assumptions:

- **Productivity:** Comparing cost of a full time PA with costs of 0.75 FTE GP/acute care doctor
- **Salary:** PA annual salary of £49,686 per FTE; GP annual salary of £94,800; an average acute sector salary of £60,000

**Employing PAs in East London for specific tasks to support GPs and acute doctors could provide an overall annual saving of £1.3m.**

In addition to these savings, PAs also attract additional cost benefits related to the cost of training - the cost of training a PA is approximately one fifth that of a doctor[^146].

[^145]: Investigating the contribution of physician assistants to primary care in England, Drennen et al, 2014
11.6 Next steps

We have committed to work with Queen Mary University of London throughout the process on the development of a PA programme.
12: Developing a strategy for the future of Mile End Hospital

12.1 The case for change

Barts Health NHS Trust acquired the freehold of Mile End Hospital (MEH) following the closure of Tower Hamlets Primary Care Trust in 2013. It took over management of the entire hospital site with the exception of Beaumont House, which is a Local Improvement Finance Trust scheme that provides a substance abuse unit for East London Foundation Trust (ELFT).

MEH is a community hospital with services offered by a range of different providers. There is a focus on mental health and primary care, with a strong emphasis on therapies and sports medicine. Barts Health currently has two acute inpatient wards on the Mile End site. These are separate from the acute beds on the Royal London Hospital site and tend to act as overspill wards from the main hospital.

Feedback from clinicians has indicated that having these separate geographical locations leads to sub-optimal clinical practice, as it is difficult for acute consultants to provide the necessary oversight and clinical presence across two sites.

Specifically, this lack of senior clinical input at MEH is one of the main constraints on reviewing and safely discharging patients more effectively and in a timely fashion. As a result, patients often stay on the wards for long periods of time and are not actively discharged home even once it is clinically safe to do so. As well as having a negative impact on patient experience, this also results in a loss of productivity and operational efficiency.

Using the MEH site as an extension of the acute bed base at the Royal London is a false economy. Not only is core clinical time sometimes wasted while consultants travel from site to site, it also takes senior clinical time away from the main site at the Royal London.

In addition, MEH also comes with significant estates challenges. The site is made up of a mixture of old and newer buildings, with the oldest built in 1858 and the newest in 2008.

The site has considerable backlog maintenance requirements as identified in the six facet survey carried out by Capita Symonds in March 2013\(^\text{147}\). The revised 2015 estimate places these costs at c. £13 million in total. Due to the age of some parts of the site, there are asbestos and potable water legacy issues that require careful management and appropriate investment.

MEH has undergone some redevelopment in recent years including: the construction of the Tower Hamlets Centre for Mental Health (a purpose-built inpatient unit); the refurbishment of Burdett House for mental health outpatient appointments and admin services; the redevelopment of the therapy unit to provide a centre of excellence for sports medicine; and the refurbishment of the Alderney building for office and support accommodation.

In order to improve the quality of acute care provided by Barts Health, the proposal is to relocate the activity currently occupying two acute inpatient wards on the MEH site into the acute bed base already located at the Royal London site.

Following the transition and vacation of the acute inpatient services there would be subsequent work to understand the opportunity this presents and how vacant ward space

\(^{147}\)Barts Health backlog update 2015 v13 (Capita Symonds 2013, revised for 2015)
and the site as a whole could be better utilised to meet the needs of the rapidly growing local population in East London.

12.2 Model of care

The relocation of the two acute inpatient wards on the MEH site would:

- allow more timely discharge for patients who would previously have been treated at the MEH site
- improve clinical quality for patients who would previously have been treated at the MEH site
- reduce clinical time spent travelling between the two sites

In order to move these patients, there needs to be a reduction in bed occupancy at the Royal London site. This is the aim of several of the main Transforming Services Together (TST) schemes, such as maternity and pathway redesign, which are also described in this document. Therefore, the changes proposed for acute inpatient wards at MEH, and options discussed for the future use of the site, only become a possibility if these other TST clinical schemes are implemented and realise their benefits.

The transfer of these acute patients to the Royal London would leave two wards vacant at MEH. This will provide the opportunity for longer-term considerations to be made into the future of the site. By developing a strategy involving all core partner organisations (including Barts, Tower Hamlets CCG, ELFT and others), a robust programme of development can be mobilised to lead the site into the future. The strategy would set out how a long-term plan would be delivered following transfer of the acute activity, and define any necessary transitional arrangements that would need to be put in place.

No decisions have been made on the services that might be provided from the site, but options include:

- Use as a step-up / step-down facility, run by Community services.
- Use as a rehab specialist unit.
- Transfer of occupancy to ELFT for increasing their mental health service provision at the site.
- Transfer for use by Barts Health Community Health Services.
- Transfer for use by alternative services (for example voluntary sector, non-health services, education or others) where appropriate.
- Closure or mothballing of the space to reduce maintenance or upkeep overheads.

Aspects of the site could also be transformed for use in other ways to compliment the local health economy in support of other local objectives. Work conducted by Capita during the summer of 2015 has identified significant opportunities for Barts Health to repurpose aspects of the MEH, such as:

- In the development of housing
- In the conversion to premises suitable for neighbouring Queen Mary’s University London
However, there are restrictions on the redevelopment potential of the site due to conditions that were agreed when MEH transferred ownership to Barts Health. For example, the trust would be unlikely to retain the cash receipt of any disposals it makes on the site (including sale to developers, for example). As a result, a broader strategic plan for the site has not yet been considered by the trust. However, the options described remain viable and will be considered in due course by the trust.

All the above scenarios would either provide financial benefits through a marginal income by tariff, a service management income to Barts Health, or reduced management costs. The work to complete the strategy will include the completion of feasibility analysis to define the optimum approach whereby the system would gain greatest benefit.

12.3 Engagement

Since the changes proposed by this scheme are relatively minor, engagement has been focused on gaining clarity around the clinical requirements of shifting acute inpatient activity to the Royal London and understanding the potential estates implications. Engagement with a broader range of stakeholders will begin following publication of this Strategy and Investment Case.

12.4 Investment costs

Due to the low complexity of this scheme there are no material costs in transferring patients from MEH to the Royal London. The benefits will be seen in operational efficiency and patient satisfaction.

There will be investment costs required to deliver the long-term strategy for the site, but these are yet to be calculated. The next phase of work will define strategic options and associate costs with each.

12.5 Impact on activity and revenue

Shifting acute inpatient activity from MEH to the Royal London will not have a material impact on revenue and as such is not modelled here. Any material implications will be defined in the next steps, which will develop the strategy for the future of the whole site.

12.6 Delivery risks

There are no material risks associated with transferring the existing acute inpatient activity to the Royal London, as the shift will only occur once capacity has been released following implementation of other TST clinical schemes.

Risks associated with delivery of a long term strategy for MEH will be defined in due course.

12.7 Next steps

The main next steps to implement the scheme will be:

1. to adapt clinical models of care to reduce, and ultimately remove all transfers to the MEH wards to allow them to be vacated
2. for the Barts Health estates team to work with partners across the system (including ELFT, Queen Mary University London, Tower Hamlets CCG and others) to develop a strategy for the future of the site

3. for feasibility studies to be completed to further the work completed by Capita, to define opportunities, benefits and risks to the local health economy, to patient safety, and to Barts Health

4. to develop outline and full business cases where necessary, to progress the preferred option(s) into more robust designs and proposals

The full strategy for the future of the site will need to be developed in the context of the overall sustainability strategy that Barts Health will develop, as the financial implications of the preferred changes may be material to the overall economics of the trust.
13: Defining a strategy for the future of Whipps Cross University Hospital

13.1 The case for change

In order to provide safe, sustainable care for the growing population in East London, we need all of our acute sites to continue to deliver high quality care. We also know these sites will need to work together in new ways to ensure that specialist and emergency care is of the highest possible quality. Developing the strategy for the future of Whipps Cross University Hospital (WX) is therefore crucial to the longer term sustainability of the local NHS.

Barts Health NHS Trust (BH) is working with local NHS partners, together with the London Borough of Waltham Forest, to develop a clear vision for the hospital. Whipps Cross has a long and distinguished history of serving local residents. It has been a pillar of our community since the beginning of the 20th Century and has provided quality healthcare to local families for many generations. But we know there are significant challenges we need to address:

- Our buildings are old and require significant investment (c. £80 million in total) to keep them safe and suitable for patient care. Current issues include:
  
  o water ingress in the basement and problems with flooring structure in places
  o mechanical and electrical installations approaching end of their serviceable life
  o asbestos in a number of areas of the hospital
  o failing lifts, poor doors and other access and safety equipment.

- Our buildings are not designed to deliver what is now required in today’s healthcare system, making it hard and expensive to operate efficiently. For example:
  
  o due to the maternity unit’s location, emergencies require the provision of an ambulance, which uses resources that would otherwise be saved if it was physically co-located with the main site.
  o Whipps Cross has one of the largest site areas for a hospital in London, at almost 18 hectares, but rates as one of the most inefficient in terms of how the site is used.

- The Care Quality Commission report in March 2015 found that Whipps Cross was delivering inadequate levels of care, with the maintenance of key facilities and equipment (such as theatre ventilation) highlighted as being insufficient.

- We are in financially difficult times and Barts NHS Trust has not been performing well; things need to change to make our services more sustainable in the longer term.

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148 Barts Health NHS Trust Estates Strategy (draft): 2013-2018
149 Anecdotal evidence: 2015
151 www.cqc.org.uk/sites/default/files/new_reports/AAAB8913.pdf
• Our population is growing and getting older, meaning more and more people are in need of treatment to keep them well. This will place further capacity pressures on Whipps Cross:
  o By 2025 we expect the number of local residents over 65 to increase by 25%.
  o This increase will be exacerbated by other changes that are occurring across north east London, for example the proposed closure of King George’s emergency department.

Our staff work tirelessly to give the best care to our patients, but we know that they can only go so far with the facilities they have.

With things as they are, doing nothing is no longer an option. We are developing a shared vision with our NHS and local authority partners. We want to write a new chapter in Whipps Cross’ history, where we see it deliver what local people need today and in the future, by delivering better and integrated services, and most importantly through improving clinical outcomes and quality of experience for all our patients.

We are at the start of what may become a long journey, to deliver our vision of improvement in our shared ability to provide good quality health and social care. We will look across the NHS and beyond to learn what works and what doesn’t, including where recent attempts to make major changes at Whipps Cross have failed, to make sure we set up this work to succeed. In particular:

• We have all the relevant East London public agencies working together from the outset, including Barts Health NHS Trust, NHS Waltham Forest Clinical Commissioning Group (CCG) and North East London NHS Foundation Trust, as well as the local authority which provides social care services and is also involved in regeneration and planning strategies.

• We have begun to involve Barking and Dagenham, Havering and Redbridge CCGs, West Essex CCG as well as their respective local authorities, together with Barking, Havering and Redbridge University Hospital Trust (BHRUT) and Homerton University Hospital as they will also need to contribute to this work to ensure we consider the broader north east London context.

• We are looking at different funding models to ensure that we can afford to implement any changes and make them financially sustainable.

• We want to involve many different groups in this process to ensure we create a strategy that we all understand and support. This includes clinicians, politicians and decision-makers in the Government – but also, most importantly, the residents and patients who will benefit.

13.2 Model of care

We have an exciting vision for the future of Whipps Cross that transforms how services are delivered and fully integrates health and social care to provide better and more sustainable services for residents and patients.

Traditional hospitals provide acute care, but this represents just one part of the patient journey that includes their GP and other primary care services, mental health and community

152 TST Demand Model; population growth data based on GLA Capped SCHLAA 2013
services, adult social care and wider public health initiatives. We want our patients’ journeys
to be defined by their needs rather than by organisational divisions, and to deliver a joined
up service across primary, secondary and social care. Effective integration of health and
social care services will help us to deliver more efficient and clinically effective services for
all. We are therefore looking at how we could adapt our estate to facilitate the integration of
different services more effectively.

Alongside health provision, other facilities could also support the way our core services are
delivered and help to provide better care for the people we treat and local residents in
general. These other facilities could include:

- third sector and voluntary services that provide sensitive palliative care
- research centres that support advances in treatment
- educational and training centres to provide learning and development for our staff
- exercise facilities to promote active living
- retail outlets for staff and visitors
- housing for key workers.

We want to consider all these opportunities in our future strategy for the site.

To help us take steps forward, there are a number of principles we’ve started to frame that
help to illustrate our thinking. We want Whipps Cross to:

- deliver the basics of care as expected in a 21st century, efficient and effective acute
  site, whilst also providing exciting ‘leading edge’ care in specialist areas (such as
  elderly care)
- be set up to efficiently and effectively deliver the initiatives articulated elsewhere in
  the Transforming Services Together (TST) programme, such as acute care (part 3,
  section 6), primary care (part 3, section 4) and surgical hubs (part 3, section 5)
- meet the health, social care and wellbeing needs of our residents (across multiple
  boroughs) in a coherent and patient-centred integrated campus
- be a community asset that is appreciated, valued, flexible to changing needs and
  used by local residents now and in the future
- provide what our local residents need and help them to transform their health
  outcomes
- be fully and sustainably staffed, innovative and flexible, support the access needs of
  all and be environmentally aware
- be appropriately financed and maintained.

We want to learn from, and build upon, examples of health and social care integration from
both the UK and further afield, which show what can be done. These include:

- The Greenich Centre in south east London combines a community health facility,
  new GP health centre, local leisure facilities as well as hundreds of homes. It
  successfully integrates all these services to create a primary care hub facility that
  helps a whole range of people, and has become a well-used and popular local asset.
Jönköping in Sweden is a well-known exemplar of a health authority that successfully integrated medical services with social care and public health to become a national leader in health quality. It is seen as a standard-bearer internationally in the comprehensive delivery of integrated care.

And there are other examples from across the NHS and internationally that we will draw ideas from, to bring the best to Whipps Cross. There is considerable space on the site, enabling us to think widely about what we want to deliver. Only around 30% of the land is currently built on, and many of the buildings are in need of major renovation; we could do a huge amount more with what we have.

Any change we propose will need to be financially affordable and deliver lasting benefits to the local area, so we will need to be creative and look at many options to test what would work best. This is just the start of the journey, but we have big ambitions.

The work will need to consider the implications of a range of different scenarios, to allow us to make the right decisions about where we go next. These scenarios will need to be evaluated to allow us to understand:

- how each will impact on the clinical outcomes of our patients and the overall health of our residents
- the experience that our patients and residents will get from using these services
- the impact on the broader health and social care 'system' across north east London
- the overall efficiencies of the health and social care system, and how it can demonstrate it will do more with less
- the impact on our local economy, in terms of jobs it creates, and investment it will bring for our people
- the technical feasibility of each scenario, including the complexity of any transformation, and consideration of any planning or development implications it might bring
- the implications on the overall financial position of the local health and social care system, both during the transformation (e.g. the capital funding to make the change happen) and once it's all complete (e.g. in the cost of operating the transformed facilities, including the cost of servicing any associated debts)
- any other risks the transformation will pose, and our ability to control them.

Over the next six months, we will develop a Strategic Outline Case (SOC), which will set out all the scenarios and make a clear argument to take forward a course of action to deliver change. If the SOC determines that a major transformation of the site is required (and affordable), then much more detailed work to develop designs and to test the feasibility of the transformation will be needed. This could take many years to complete. In such a circumstance, we may not see any physical transformation completed for possibly up to 15 years from now, but it is important we take the necessary steps to explore all the opportunities and embark on this journey together.

In parallel to completing the SOC, we will deliver a full review of the current condition of the site and develop a robust short-term investment strategy. The information we have on the current condition needs to be revisited to allow for an effective prioritisation of the investment necessary to keep the site safe in the short term, deliver the critical changes as required by
CQC, reduce inefficiencies, and deliver what is needed to implement our TST schemes. By aligning with the outputs of the SOC we may then be able to deprioritise and even avoid some back-log requirements as the longer term strategy to transform the site will be clear. Delivering all of this may require considerable capital investment, and funding any change presents the largest risk to this work. We are already engaging with stakeholders in Government and elsewhere to help us understand and mitigate this however possible.

13.3 Engagement

Engagement has so far involved senior individuals from the partner organisations involved, plus selected others. Examples include:

- Chief Executive Officer (CEO), Director of Strategy, Director of Estates for Barts Health
- Managing Director, Medical Director, Hospital Director, Chief Nurse and senior clinicians at WX
- Councillors, the CEO, Deputy CEO, Assistant CEO and management board from London Borough of Waltham Forest
- Chair, Chief Officer and Chief Financial Officer, plus management team of Waltham Forest CCG
- CEO, Director of Operations, Director of Estates of North East London Foundation Trust
- Iain Duncan Smith (MP for Chingford and Woodford); Stella Creasy (MP for Walthamstow); John Cryer (MP for Leyton & Wanstead)
- Cabinet Office/Local Government Association individuals who run the One Public Estate programme

There has been some engagement with patient representatives, Healthwatch and other local residents groups, but this will increase considerably as we mobilise to complete the Strategic Outline Case. The outcomes of this work will be best shaped with input from these groups, and we will actively seek to involve them in our plans as they start to take shape.

13.4 Outcomes the change will achieve

The Strategic Outline Case (SOC) will articulate the next steps for the preferred option(s). These next steps may involve development of Outline and Full Business Cases. The table below illustrates an indicative timeframe for delivery of these products:
<table>
<thead>
<tr>
<th>Outcome description</th>
<th>Outcome by 2020/21 (Metric/impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of a robust Strategic Outline Case for the future of the WX site</td>
<td>By summer 2016</td>
</tr>
<tr>
<td>Complete prioritisation of the short-term investment requirements (to clear back-log maintenance) and agree capital programme</td>
<td>By summer 2016</td>
</tr>
<tr>
<td>Complete works on critical back-log</td>
<td>By summer 2018</td>
</tr>
<tr>
<td>Delivery of a robust Outline Business Case for physical transformation (if required)</td>
<td>Summer 2018 (TBC)</td>
</tr>
<tr>
<td>Delivery of a robust Full Business Case for physical transformation (if required)</td>
<td>Summer 2020 (TBC)</td>
</tr>
<tr>
<td>Approval to commence with transformation</td>
<td>Autumn 2020 (TBC)</td>
</tr>
</tbody>
</table>

13.5 Investment costs

The table below illustrates the level of programme management costs required to deliver the strategy from strategic outline case through to final build.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme costs</td>
<td>£8.2m</td>
<td>£8.2m</td>
<td>£8.2m</td>
<td>£8.2m</td>
<td>£8.2m</td>
<td>£41m</td>
</tr>
</tbody>
</table>

13.6 Impact on activity and revenue

There will not be any impact on activity until the Full Business Case has been approved (c.2020) and construction can then commence. The SOC/OBC/FBC process will define the impacts on activity and revenue for the trust and local health economy (including social care).

Revenue impacts will only be on funding the SOC/OBC/FBC programme; costs are likely to be capitalised.

13.7 System commercial considerations and transitional support required

Commercial considerations will be made during the SOC process. Delivering a sustainable funding model for the site may require evaluation of a range of commercial opportunities that could feature on the site, including for example:

- Medical research
- Leisure activities (e.g., private gymnasium or hotel)
- Housing
- Retail outlets
- Car parking
- Private practice.

### 13.8 Delivery risks

<table>
<thead>
<tr>
<th>Description of risk</th>
<th>Risk Likelihood</th>
<th>Risk Impact</th>
<th>Risk rating</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There is insufficient funding available to support delivery of the SOC</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>BH investigating potential to capitalise spend Contributions from partner organisations being investigated Clear definition of the case for change and the risks to patients of the ‘Do Nothing’ position</td>
</tr>
<tr>
<td>Barts Health is in special measures and will mean scrutiny by the National Trust Development Agency will be necessary; approval may not be given</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The WX SOC needs to be written in the context of a broader Barts Health strategy; without this the WX SOC could fail to gain approval</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>Barts to mobilise a central programme to define the sustainability strategy for the trust; work must proceed in parallel</td>
</tr>
<tr>
<td>3. Key posts in Barts Health are still interim; risk that permanence of the outcomes are jeopardised by changing leadership</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>Developing a cross-system approach will distribute the ownership to a number of system leaders</td>
</tr>
<tr>
<td>4. Central Government does not support a major investment in East London</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Clear articulation of the system-impact of all strategic options for the site will be necessary Commenced discussions with local MPs;</td>
</tr>
<tr>
<td>5. Risk of ‘fall-out’ with staff and local residents if the programme over promises what it can deliver; risk of bad publicity and deterioration in staff morale (already fragile)</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Approach must be very carefully managed to ensure messages are always caveated appropriately</td>
</tr>
</tbody>
</table>
13.9 **Next steps**

The following next steps will govern progress in delivery the SOC:

- Barts Health to agree budget to deliver the SOC.
- Recruitment of the Programme Director to be completed.
- Procurement of Programme Team to deliver the SOC programme.
- Planning and mobilisation.
- Definition of requirements for technical support (architects, planners, engineers etc) and commence procurement.
- Complete SOC for approvals April/May 2016 and plan for OBC phase.