Overview & Scrutiny

Inner North East London Joint Health Overview and Scrutiny Committee

All Members of the Inner North East London Joint Health Overview and Scrutiny Committee are requested to attend the meeting of the Committee to be held as follows:

Monday, 7th November, 2016,

6.30 pm
London Borough Tower Hamlets -Room MP701, Mulberry Place, 5 Clove Crescent, East India Dock, E14 2BG

Tim Shields
Chief Executive, London Borough of Hackney
Contact:
Jarlath O'Connell
☎ 020 8356 3309
✉ jarlath.oconnell@hackney.gov.uk

Members: **Cllr Ben Hayhurst, Cllr Ann Munn and Cllr Clare Potter**
Co-Optees

Agenda

ALL MEETINGS ARE OPEN TO THE PUBLIC

Hackney

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Inner North East London Joint Health Overview and Scrutiny Committee 07 November 2016 **Minutes of the previous meeting**	Item No **3**

OUTLINE

Attached please find the draft minutes of the meeting held on 25 July 2016.

ACTION

The Committee is requested to agree the minutes as a correct record.

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MINUTES OF A MEETING OF THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MONDAY 25 JULY 2016

Meeting held at 7.00 pm at Hackney Town Hall, Mare St, E8 1EA

Committee Members present:

City of London Corporation
Common Councilman Wendy Mead OBE

Hackney Council
Cllr Ann Munn
Cllr Ben Hayhurst
Cllr Rosemary Sales

Newham Council
Cllr Susan Masters (in the Chair)

Tower Hamlets Council
Cllr Sabina Akhtar
Cllr Muhammad Ansar Mustaquim

Member apologies:

Hackney Council
Cllr Clare Potter
Tower Hamlets Council
Cllr Clare Harrisson
Newham Council
Cllr Anthony McAlmont

Officers in attendance:

Tower Hamlets CCG: **Jane Milligan (Chief Officer)**
Newham CCG: **Steve Gilvin (Chief Officer)**
City and Hackney CCG: **David Maher (Deputy Chief Officer)**
Barts Health NHS Trust: **Dr Alistair Chesser (Chief Medical Officer) and Ralph Coulbeck (Director of Strategy)**
NHS NEL CSU (TST Team/STP Team): **Neil Kennett-Brown (outgoing Programme Director NEL STP); Nichola Gardner (incoming Programme Director NEL STP); Dr Kate Adams (GP and TST Clinical Lead for Out of Hospital Programme); Don Neame (Director of Communications)**
City of London: **Neal Hounsell (Scrutiny Lead Officer)**
Hackney: **Jarlath O'Connell (Overview & Scrutiny Officer)**
Newham: M**ichael Carr (Scrutiny Manager)**
Tower Hamlets: **Daniel Kerr (Strategy, Policy and Performance Officer) and Joseph Lacey-Holland (Senior Strategy, Policy and Performance Officer)**

Also in attendance:

Carol Ackroyd (City & Hackney Keep Our NHS Public)
Nick Bailey (City & Hackney Keep Our NHS Public,
Dr Coral Jones (City and Hackney BMA)
Dr Nick Mann (City and Hackney Keep Our NHS Public)
Carol Saunders (Tower Hamlets Keep Our NHS Public)
Jan Savage (Tower Hamlets Keep Our NHS Public)
Michael Vidal – member of the public

1. ELECTION OF CHAIR AND VICE CHAIR

1.1 The Overview & Scrutiny Officer opened the meeting and invited nominations for Chair.

1.2 Cllr Munn, the outgoing Chair, stated that Cllr Harrisson had to give her apologies for this meeting but had put her name forward for Chair. Cllr Harrison was proposed by Cllr Munn and seconded by Cllr Masters. Following a show of hands Cllr Harrisson was elected as Chair. Cllr Mustaquim abstained.

1.3 The Overview & Scrutiny Officer asked for nominations for Vice Chair.

1.4 Cllr Munn proposed Cllr Masters and Cllr Hayhurst seconded. Following a show of hands Cllr Masters was elected unanimously as Vice Chair.

1.5 In the absence of the Chair, Cllr Masters as Vice Chair chaired the meeting.

2. APOLOGIES FOR ABSENCE

2.1 Attendees were welcomed to the meeting and introductions were made.

2.2 Apologies for absence were received from Cllr Anthony McAlmont (Newham), Cllr Clare Harrisson (Tower Hamlets) and Cllr Clare Potter (Hackney)

2.3 It was noted that it was customary for the Health and Social Care Scrutiny Chairs from London Borough of Waltham Forest to be invited to the meeting as observers and Cllr Masters welcomed Cllr Richard Sweden (Chair, Social Care Scrutiny Committee, LBWF) to the meeting.

3. URGENT ITEMS/ ORDER OF BUSINESS

3.1 There were no urgent items and the order was as on the agenda.

4. DECLARATIONS OF INTEREST

4.1 Cllr Hayhurst stated that he was a member of the Council of Governors of Homerton University Hospital NHS Foundation Trust.

4.2 Cllr Masters stated that she had been a founding secretary of the Newham Save Our NHS Group.

5. MINUTES OF THE PREVIOUS MEETING AND MATTERS ARISING

5.1 The minutes of the meeting held on 26 October 2015 were agreed as a correct record. There were no matters arising.

6. NHS NORTH EAST LONDON SUSTAINABILITY AND TRANSFORMATION PLAN

6.1 The Chair welcomed the officers for this item in particular the Chief Officer for the NEL STP Jane Milligan (JM) who was also the Chief Officer of Tower Hamlets CCG and Steve Gilvin (SG) (Chief Office, Newham CCG).

6.2 Members' gave consideration to the briefing paper on the STP.

6.3 In introducing the report JM described the Partnership Steering Group of the NEL STP Board which had on it the Chief Executive of Waltham Forest Council who was the main local authority link.

Questions and answers

6.4 Cllr Hayhurst stated that while he was sympathetic to the fact that the STP process had been foisted on them and with a quick timescale for delivery, underpinning it all was a £928m deficit in the sub-region over 5 years. He added that the aims were laudable. He asked whether the changes were going to be focused around centralising operations and what commitments could be given on maintaining current levels of provision, overall.

6.5 JM replied that the Transforming Services Together programme was an important plank of the STP. They key was bringing together Barts Health and BHRUT so as to focus on where the right care can be delivered.

6.6 Cllr Munn stated that JM had written to lead Members the day after the draft Plan had been submitted and reference had been made to how vital integration with social care was to delivering this overall programme. It also referred to a single NEL plan for investments and disposals and she asked what commitments could be given on ensuring that surplus NHS property would be put to use locally.

6.7 JM replied that they had to write the JSNAs for the NEL area to determine how they might utilise existing loops in the system. It was perhaps not as consistent as they would have liked but, for example, the local Hackney Pilot was a key part of the overall plan. Cllr Munn commented that the plans thus far had not detailed what might move or what might close and that patient groups would surely find this confusing.

6.9 Mrs Mead asked whether the PFI burdens on Barts Health might lightened in any way.

6.10 JM replied that they realised there were indeed significant challenges on the Trust but in the STP there were no specific requests around support on the PFI issue. Steve Gilvin (SG) added that some relief around excess costs was important and they would be arguing the case for that more broadly. Cllr Hayhurst asked about the £53m savings goal for Barts vis a vis the £63m to be saved from infrastructure. If that £53m was PFI this would mean only £10m savings needed to be found therefore in this STP process. SG replied

that the door wasn't closed on the PFI discussion. The priority was to produce a plan that had the potential to solve all the problems and if through this process part of the financial burden of the PFI could be unlocked that would be greatly welcomed. Cllr Hayhurst commented that if the PFI debt could be repackaged a case could be made here. SG replied that other areas had had relief of PFI costs built into their (STP) solutions e.g. BHRUT had some PFI costs subsidised, so there was precedent in this patch. There were difficulties in re-packaging and refinancing a deal of this complexity. Neil Kennett-Brown (NKB) clarified that there were £10m in estates running costs but a further £16m in the revenue model. This was not about reconfiguring the whole estate and making disposals but rather about ongoing costs.

6.11 Mrs Mead asked whether progress had been made on the new private wing at St Bartholomew's.

6.12 Ralph Coulbeck (RC) replied that they were in the progress of finalising arrangements with a third party and there was no fully agreed position as yet. It would go some small way towards easing the financial burden on the Trust.

6.13 Cllr Masters asked what engagement had there been with LMCs on GP issues?

6.14 JM replied that there was a clear aim to have a strategy for primary care. They had had discussions with Dr Jacky Applebee, the Chair of Tower Hamlets LMC, on how to engage further with GPs and they would take this forward through the Transforming Services Together programme.

6.15 Michael Vidal (MV) asked about a letter sent from NHS Improvement to Trust Chief Executives dated 19 July on the consolidation of services and asked in particular what the early thinking was on the consolidation of pathology services and what services they would consider unsustainable.

6.16 RC replied that they were not providing any services which reached the criteria for unsustainability as had been set out. On pathology a plan had not yet been worked up but Barts Health operated a hub and spoke model and there would be an opportunity now to look at how services could be improved. JM added that there was a recognition that NEL was different from many others in that the area had experienced a significant population growth and this was being built into the plan.

6.17 MV asked what assessments had been made on the impact on the STP of Barts Health now being placed in financial special measures.

6.18 JM replied that she didn't think this development would impact in particular on the STP. They would work closely with NHSE on solutions. SG added that he was not entirely clear what it would mean for the wider health economy in east London. They continued to believe that TST was the right plan and that hadn't changed.

6.19 Dr Nick Mann (NM) (City and Hackney Keep Our NHS Public) stated that as a local GP he was very keenly aware that all the providers were in substantial deficit and that The King's Fund had been very clear that this integration plan constituted 'magical thinking'. He stated that experiences from the USA showed that Accountable Care Organisation models didn't save money nor did they improve care. He stated that the STP was light on detail on how this might save money without closing a major hospital. The savings of 50% from productivity and 50% from the workforce were totally unachievable, in his opinion. The plan envisaged cutting the GP workforce by 10% over 5 years (from 600 to 400 GPs) and how did this made sense in the context of a 60% cut in hospital beds in the region since 1987.

6.20 Dr Kate Adams (KA) replied that there would be not cuts to GP Practices. They were trying to be realistic about the situation and to think differently about how primary care was delivered. They were looking at how to make greater use of nurses and pharmacists in primary care whilst keeping GPs for the more complex problems.

6.21 Carol Saunders stated that the area would have a rise in population the size of Brighton & Hove yet they were talking about having to make savings of £104m and £165m.

6.22 SG replied that this was not about taking money out. It was about how to find a way to improve the quality of care. It was a big ask to close the quality and financial gaps he added.

6.23 Dr Coral Jones stated that this was reorganisation was happening by stealth and GPs had not be properly consulted. Decisions were being made by Transformation Boards and it was insulting to local GPs. These were not our solutions she added. It involved cutting of 2/3 of funding compared to other areas and care closer to home would lead to the burden being put on unpaid carers. There was no evidence that these "new ways of working" actually worked and this was fantasy thinking. Nobody was talking about the harm which would ensue, she added.

6.24 SG stated that the TST Plan had been built very carefully on strong engagement with local GPs and they had spent a lot of time at meetings with the various GP clusters. He reminded Members that the CCGs who are driving this are also GP led organisations.

6.25 Carol Ackroyd stated that they were aware that the region couldn't say to NHSE that this was undoable as that would risk future transformation funding but it was important to make sure there was opposition to this iniquitous plan. There was a need for a massive campaign nationally to make clear that this was not acceptable, she added, and national NHS campaigns around the country would support local CCGs on this.

6.26 JM replied that part of the challenge was to work on the local plans. From discussions she had had nationally this plan, in her view, represented an opportunity to provide evidence to feed in to the next Comprehensive

Spending Round. It was important that North East London did not miss out by not having a plan of its own that was credible. NKB added that this was not about cuts but about growth. £4.1bn came into NEL annually and this would be £4.5bn in 5 years' time. There would be a growth in funding. The challenge was that, with the population growth and the higher rate of inflation used in NHS calculations, there would be a shortfall. The NHS was still in a better position than local authorities, he added, which were facing cuts of 20-30%. There was a productivity challenge as well as a savings challenge. There was also, he added, waste in the system and a need to get the whole system to work more effectively.

6.27 The Chair thanked the officers for their briefing and their attendance.

RESOLVED:	**That the report and discussion be noted.**

7. 'TRANSFORMING SERVICES TOGETHTER' UPDATE

7.1 Cllr Masters stated that the Committee last had an item on TST in October and in February there had been an informal meeting in Stratford on the development of the consultation plan. They public consultation had now taken place and the Committee had asked Neil Kennett-Brown and colleagues to return to the Committee to present what they found during the consultation and to discuss the next steps. The same officers for item 6 remained for this item.

7.2 Members gave consideration to the report '*Transforming Services Together – report of engagement*'.

7.3 SG and RC took members through the report and RC detailed the proposals relating to surgery. SG thanked the Save our NHS and the Keep Our NHS Public groups in the three boroughs for their detailed responses. He stressed that in no way did these proposals undermine A&Es or surgery in any of the hospitals and they would now be looking to implement the proposals.

7.4 Cllr Masters stated that while the NHS had consulted a large number of groups here they had done so at a very superficial level and it was only when she had gone through the full 173 pages document did she understand the full implications. When she had presented it to the Patient and Public Involvement Group in her local GP Surgery they had been very surprised by its implications.

7.5 Don Neame (DN) (Director of Communications, NHS NEL CSU) stated that they had spoken to a thousand people on this consultation and these changes would of course not be happening overnight. The principles had been signed up to early on. The Patient Reference Groups involved the Healthwatch organisations in each borough and they wanted to be involved further.

7.6 Cllr Masters stated that one thousand contacts was nothing considering the population size and asked what the timetable was for implementation.

7.7 DN replied that the CSU's view was that they did not need to consult further The consultation had been for new ideas. It would not be necessary to consult on every extension of the existing Plan.

7.8 DN pointed to the issue of Physician Associates as an illustration stating that there were already two currently working in Tower Hamlets so this would not be an innovation within the TST area. Cllr Masters expressed the concern that there were only 2 overall and none in Newham so there would be no awareness there of the role or its implications. She asked when would there be a formal Case for Change proposal.

7.9 DN replied that that had been made two years previously.

7.10 Cllr Hayhurst stated that the NHS had a statutory obligation to come to this committee for health service changes of this magnitude. DN replied that they didn't believe that this constituted a significant case for change. Cllr Hayhurst asked what the total budget saving was here. DN asked if the Cllr was stating that it in the legislation it was to do with money. Cllr Hayhurst stated that Scrutiny Committees had received Case for Change proposals on changes which had been significantly smaller than here. DN and Cllr Hayhurst agreed that the legislation did not specify financial limits.

7.11 SG stated that on the back of the original proposal they had now produced a business case. There would be a £400m budget gap if they did nothing here. Because they were not changing the acute portfolios this did not constitute a formal case for change.

7.12 Cllr Hayhurst took issue with this and stated that on the point of engagement and on the point of procedure there was a statutory obligation here which had to be observed. The changes to cancer pathways hadn't fallen into this definition yet they had come to Scrutiny. What happened had been a very broad brush consultation, in his opinion. It was a very large overview with no costings and it had missed out the middle phase and now the NHS appeared to be headed to implementation. . This was about democratic procedures and this didn't fit he added. He stated that he was concerned about this and the Committee could refer this to the Secretary of State on the basis that they had not been properly consulted.

7.13 SG replied that if there were areas where they wanted further information this could be provided.

7.14 Cllr Hayhurst stated that what Members had been after from the outset was a financial line by line on the proposed changes. £400m was one and a half times the budget of the Homerton and this was a significant change.

7.15 NKB stated that they had a summary document which was 110 pages and a third document which had a financial narrative. Cllr Hayhurst repeated that what the Committee wanted was a line by line financial breakdown. He read from the statutory instrument and relevant guidelines here which listed the

occasions when there is a duty to consult and he concluded that this was the case in this situation, acknowledging that the definition of 'substantial variation' had not been tested in the courts.

7.16 Cllr Munn added that the NHS had merely sought comments on the broad thrust of these proposals and were now suggesting that the Committee go along with these changes.

7.17 Cllr Masters, in the Chair, stated she would like a meeting to be arranged in September to establish from officers what was need to be presented in order to make progress here and a formal meeting to consider a case for change document could follow. SG undertook to take this away and discuss further with colleagues.

7.18 Cllr Mustaquim asked what the impact of Brexit and the fall in value of sterling would have on the area of recruitment in local NHS bodies.

7.19 SG replied that he was not sure whether they would need to be reviewing strategy on Brexit in the context of TST but he would take this away.

7.20 Cllr Sweden (Waltham Forest) stated that he had been involved in various case for change proposals in the past and one general point in relation to patient flows was that patients generally wanted to move towards the centre and not outwards, when services were being consolidated to central locations. He also asked about the plans to sell off land on the site of Whipps Cross and asked what provision if any was being made to secure affordable accommodation for clinicians and medical staff.

7.21 RC replied that the point about patient flows in relation to surgery was well made. In relation to key workers he stated that it was a key part of any estates redevelopment plan. Barts Health was working closely with Waltham Forest Council and the CCG on this.

7.22 MV asked if progress wasn't made on TST would NHS Improvement take the initiative here and make these changes anyway.

7.23 SG replied that there was a lot of detail in the Investment Case. There was always a risk of this but they wanted to work together with local partners to make it their plan.

7.24 Dr Mann stated that he had concerns about redeployment of services being done by decree. There were issues with care at home and he was worried that there was evidence that home monitoring did not work. It didn't lower costs and didn't improve care, in his opinion. Overall TST represented a downscaling of plans and there would less than half the number of GPs locally in 10 years' time, yet demand was increasing. Downscaling triage makes things worse and there was no need to redesign the whole service. This plan was dangerous he concluded. His fear for the future was that when it got to a stage where this Plan was not working, the Secretary of State would then step in and Lewisham Hospital had set a precedent for this. There was a need to

challenge these grand schemes and not be subservient to them. Who was going to pick up the rising demand he added.

7.24 KA replied that a lot was being done on transforming GP care. She worked in urgent care and she also was the lead on End of Life Care. She was adamant that improving quality could also improve costs. The point of this programme was to look at how the sector could be more innovative.

7.25 Cllr Masters, in the Chair, reiterated the need for a meeting to discuss what could be formally presented to the Committee at the next meeting. Cllr Hayhurst commented that it appeared that proposals were scheduled to be presented to CCGs in October. Cllr Masters asked whether the NHS would now agree to delay this.

7.26 SG stated that he would discuss with stakeholders. It was noted that Neil Kennett Brown would be moving on from his current role.

7.27 Cllr Munn stated there was a need to agree which chunks of the TST could come forward in more detail as part of a case for change adding that, in her view, all elements would have to come at some stage.

7.28 The Committee agreed that there be an informal planning session with officers in September followed by a formal committee meeting on TST in October or November.

ACTION:	**INEL Scrutiny Officer Lead to set up a meeting between Cllrs Harrisson, Masters, Munn and Hayhurst with Steve Gilvin and the STP Programme Director in September to establish what needs to be presented to the next formal meeting of the Committee to be scheduled in October/ November.**

RESOLVED:	**That the report and discussion be noted.**

The meeting concluded at 8.50 pm.

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Inner North East London Joint Health Overview and Scrutiny Committee 7th November 2016 **Transforming Services Together (TST)**	Item No **6**

OUTLINE

At the INEL meeting on 25th July 2016, members requested that the Chair & Vice-Chair meet with senior officers from the relevant CCGs to discuss bringing more detailed reports regarding the *Transforming Services Together* (TST) programme to committee. The minutes of that meeting are included in this agenda.

The Chair and Vice-Chair met with CCG Chief Officers on 29th September 2016 and it was agreed that INEL would host two meetings in November for more detailed scrutiny of the TST across specific areas of concern identified by members.

This report and its accompanying summary include items covering:

- The financial implications of TST and progress on delivery;
- Modelling for the future of the primary care workforce.

The following INEL meeting which will take place on 17th November will explore TST further, receiving a report covering plans for self-care, elective care, and movement of services and patient journeys.

ACTION

The Committee is requested to give consideration to the report and discussion and provide comments.

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Transforming Services Together

Report to the Inner North East London Joint Health and Overview Scrutiny Committee

7 November 2016

Contents

1. Introduction

The following information supports a presentation to the INEL JHOSC.

At a meeting between the INEL JHOSC Chair and Vice Chair and CCG Chief Officers it was agreed to arrange two meetings to discuss specific elements. The two meetings have been scheduled to allow sufficient time for a more detailed debate on key proposals to inform future plans.

This meeting sets out:

- Financial implications and progress
- Workforce implications and progress.

A meeting on 17 October 2016 will discuss:

- Self-care and progress
- Elective care and progress
- Movement of services and patient journeys and progress.

The information summarises and updates the information provided to the public and stakeholders during the engagement period (29 February to 31 May 2016) in the strategic investment case http://www.transformingservices.org.uk/strategy-and-investment-case.htm

2. Summary of Financial Implications

Further published detail can be found in the strategic investment case at:

- Part 2 (Main report) page 16: The financial case for change
- Part 2 (Main report) page 61: Financial and activity assessment. This describes the expected revenue and capital impacts of TST in conjunction with expected activity
- Part 3 (High impact changes): Describes the investment costs and impact on activity and revenue for each of the 13 high impact changes.

2.1 Summary of Demand and Spend

Total current annual CCG expenditure on healthcare services in Waltham Forest, Newham and Tower Hamlets is £1.16billion[1], providing an associated bed base of 6,498 across acute, community care, primary care and mental health sectors. The three CCGs are all forecasting a small surplus in 2016/17.

Over 52% of this amount is commissioned from the main acute provider Barts Health NHS Trust. At approximately £608m in 2016/17, the remainder being comprised of smaller acute providers, primary care, mental health, community services, and continuing/other services.

There is an ever-increasing demand for healthcare services in the area, driven by demographic increases in the age and size of the population. This increasing demand leads directly to increased costs for the provision of services, forecast to be some £236million a year extra by 2021, giving a 20% increase in cost over the next five years.

2.2 Summary of Funding Allocations

Nationally, against this rising level of demand and costs there is relatively constrained funding growth for the NHS (of c1.1% per annum). Local total recurrent funding allocated to WEL CCGs is forecast to increase in each of the next five years, above the national average because of our increasing population. So by 2020/21 we will receive over £142million a year more than now. Although this is a significant amount of increase, it will not cover the costs of increasing activity.

2.3 Combined Financial Forecast

Combining the demand and resourcing trends into a local perspective, Figure 1 illustrates the widening gap between CCGs' funding and the forecast increase in cost arising from increasing healthcare demand. Although annual funding is anticipated to rise at a rate of c.2.8%, demand and investment costs are expected to rise faster at a rate of approximately 3.8% per annum.

[1] This spend does not include a) patients living in other boroughs which will have their own method of ensuring efficiency and sustainability b) areas of specialist healthcare commissioned and funded by NHS England.

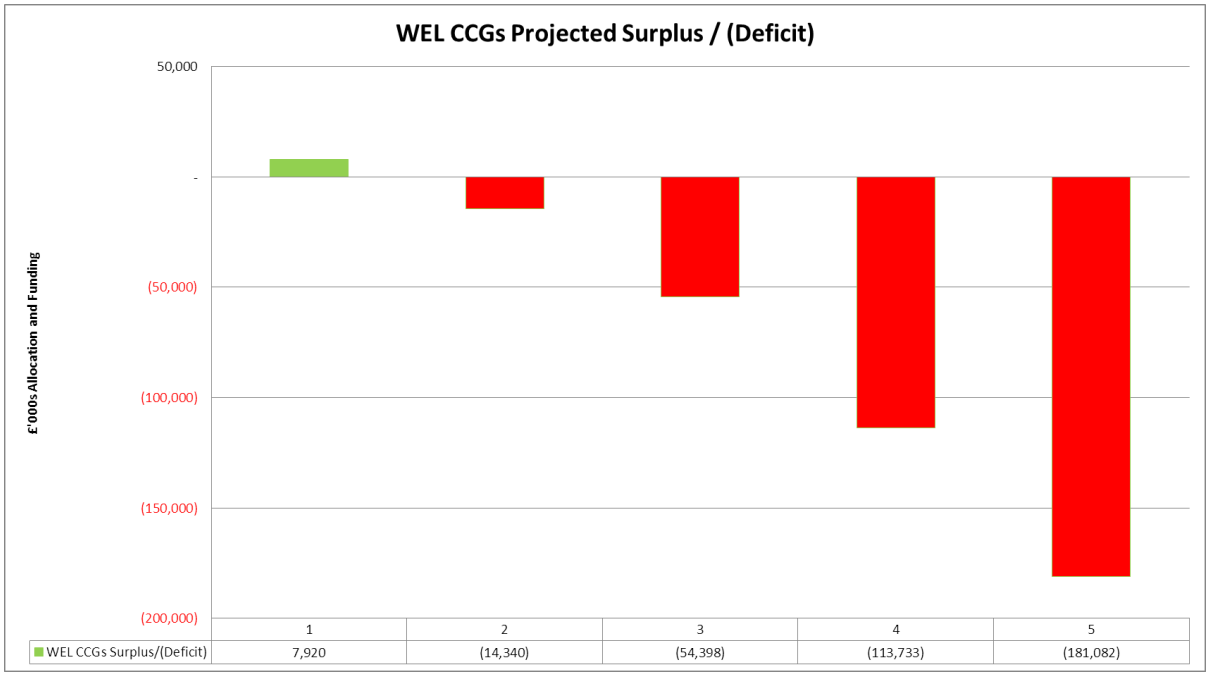


Figure 1: WEL CCGs' financial performance without TST programme[2]

2.4 Commissioner Deficit and Savings Challenge[3]

- Because of the growth in demand (both by the existing population and the population growth) and the investments required, by year five there will be, if no action is taken, a recurrent commissioner deficit of £181million which is likely to be unsustainable, even in the shorter term. This will be associated with a larger accumulated deficit of (c. £355million) over the five year period.
- The redress of this deficit and the achievement of financial sustainability will be principally met through changing the methods of healthcare delivery so that the same or better healthcare outcomes are achieved through a less costly process, a significant element of this is to be delivered by the TST Programme.

The TST programme is designed to try to seek these efficiencies through transformational service redesign. There are currently 12 work streams being implemented which are felt to have the largest possibility of delivering the necessary efficiencies whilst either improving or not adversely affecting service quality.

These schemes will come into effect gradually over the next five years reaching maximum effect by 2020/21. The final efficiency saving level is currently forecast to be £46.2million recurrently by 2020/21. The phasing of these schemes is shown below:

[2] The gap between funding, expenditure and the indicated surplus/(deficit) is the requirement for CCGs to save a 1% annual surplus.

[3] The figures do not include the TST footprint provider deficit which is associated largely with Barts Health NHS Trust. The TST forecasting assumes that the size of the annual deficit will decrease slightly over the coming years driven by: increases in tariff prices paid per unit of healthcare activity; and the achievement of internal cost improvement plans internally reconfiguring service to reduce the unit cost of each element of healthcare delivery. By year five the annual provider deficit is expected to be (c. £38m) albeit with a significant accumulated deficit.

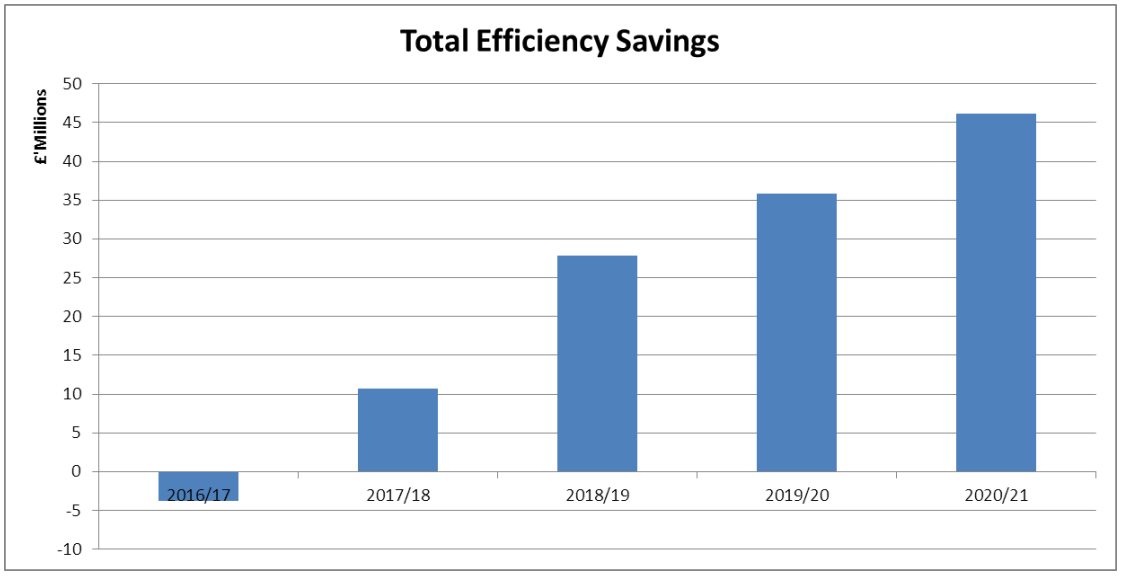


Figure 2: Projected TST efficiency savings

These savings are split across the 12 work streams shown below – approximating to a 4% efficiency saving by 2020/21. It is worth noting that the savings are the difference between the costs of the growing demand provided in the traditional way and providing the same services in a new, more efficient way. The efficiency savings figures do not represent a net reduction in the investment in any service; they are simply a measure of efficiency gain.

Workstream	2016/17	2017/18	2018/19	2019/20	2020/21	Total
Primary Care	-	1,598,187	4,286,820	(155,756)	1,481,691	7,210,942
Urgent Care	-	1,955,640	1,992,443	2,020,617	2,045,757	8,014,457
Integrated Care	-	185,712	365,356	305,030	244,834	1,100,932
End of Life Care	61,564	82,093	121,700	138,049	127,417	530,823
Acute Care Hubs	3,407,805	7,029,725	11,295,188	16,195,403	19,229,160	57,157,280
Surgical Hubs, incl. IR	-	-	-	-	-	-
Modern Maternity Care	971,682	993,068	1,310,432	1,334,329	1,567,692	6,177,203
Outpatient transformation	1,681,963	5,139,053	10,457,772	14,205,690	18,043,384	49,527,862
Reduce unnecessary testing	1,466,073	4,399,331	6,599,327	8,799,252	8,799,252	30,063,235
Shared Care Records	(1,042,196)	(1,687,810)	(1,883,143)	(1,807,724)	(1,932,213)	(8,353,086)
Physician Associates	-	-	184,108	1,069,240	2,902,916	4,156,264
Whipps Cross Hospital	(143,500)	(430,500)	(717,500)	(1,004,500)	(1,291,500)	(3,587,500)
Pump priming Costs (Non Recurrent)	(10,125,389)	(8,503,520)	(6,120,832)	(5,293,659)	(5,058,235)	(35,101,633)
Total Savings	(3,721,998)	10,760,980	27,891,670	35,805,973	46,160,154	116,896,779

Figure 3: TST efficiency savings (black) and investment (red)[4]

[4] Surgical hubs show no efficiency savings for commissioners as all savings are internal to Barts Health

These savings are based on the schemes below:

Work stream	Key points
1. Primary care	Improve access, coordination and patient empowerment. To do this we need smaller practices to work together so that patients can access more services in the community at times that suit them. Savings generated from the sustainability of primary care practice.
2. Integrated care	Extend integrated care to those at medium risk of hospitalisation (it is currently available to high risk patients) and provide care in the patient's home or in the community to help them stay well or manage their illness. Savings from reducing hospitalisation of those patients who do not absolutely require it.
3. Urgent care	Develop a single point of access with the ability to appropriately redirect patients to self-care services and/or book patients into local clinical services over a 24 hour period.
4. End of life care	Enable staff to have conversations with patients to ensure we understand their wishes, establish better partnership working and put in place specialised services to support more patients to be able to die in their choice of location. Savings from releasing hospital capacity currently used by those patients who would prefer to die elsewhere.
5. Improving surgical services	Create centres of excellence at each hospital by bringing together surgical services. This would a) support the viability of these hospitals b) release much-needed capacity at Royal London c) provide a better patient experience (and outcomes), reducing cancellations and waiting times. Pre-operative and post-operative care would be at the patient's local hospital.
6. Acute care hubs	Bring together clinical areas focused on rapid assessment, treatment and recovery. This would allow more people to be seen and treated quickly, avoiding the need for admission to a bed, which can occur, for example, whilst patients wait for tests.
7. Modern maternity care	Provide more informed choice and continuity of care to increase the proportion of natural births (usually midwifery-led).
8. Outpatient transformation	Improve the quality of referrals, make better use of technology, so that people can receive a consultation without having to travel to hospital (where appropriate) and improve the effectiveness of patient pathways across a range of specialties.
9. Reducing unnecessary testing	Reduce the number of high-cost unnecessary tests requested by some GPs. Consider GPs being able to directly refer patients for hospital tests (rather than to a hospital consultant who then does the referral). Improve IT to share tests.
10. Shared care records	Invest in the roll out of an 'East London Care Record', ensuring records are secure, accessible (both to read and to add comments and treatment given) and are used by staff.
11. Workforce including physician associates	Looking at introducing new workforce models, including the role of physician associates and pharmacists. Also it became clear during engagement that the work stream needed a wider remit around recruitment and retention, developing the workforce and promoting 'east London as a destination'.
12. Whipps Cross Hospital	Prepare for the re-design and rebuild of a full service hospital at this site.

Applying these work stream savings to the forecast c355million deficit in 2020/21 (£181million deficit after we take into account the income growth) would of course leave a significant gap. The chart below (figure 7) shows the impact of the TST savings as an element of the proposed improvement to the 2020/21 position[5].

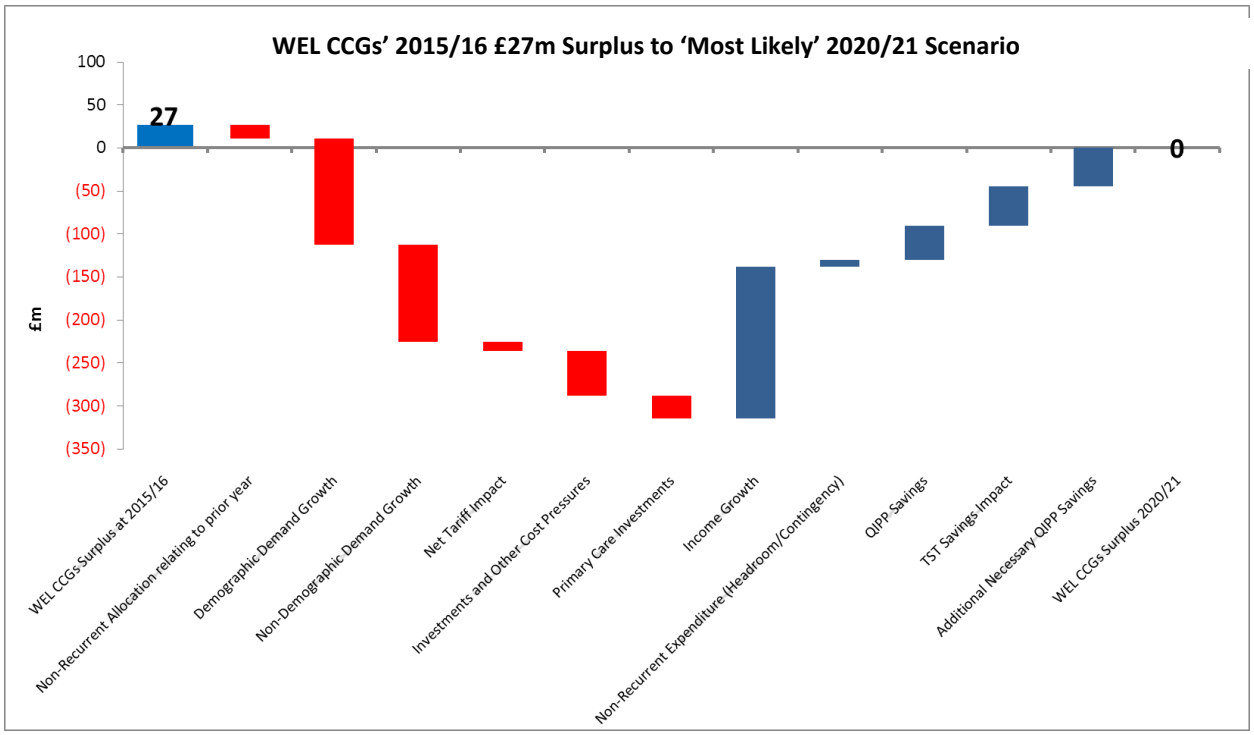


Figure 4: How CCGs will bridge the funding shortfall

As can be seen TST efficiency is significant, but far from the only element in addressing the savings need by 2020/21.

It is worth noting that all of the proposed savings will not lead to a reduction in the overall resource expended on healthcare in Waltham Forest, Newham and Tower Hamlets; indeed the total expenditure continues to rise in every year of the programme period.

2.5 Capital Costs

Many elements of the WEL healthcare estate are ageing and in need of repair. There are significant capital expenditure requirements to progress these schemes. In addition, failure to seek efficiencies in the delivery of healthcare services would impose a capital spend requirement to design and build an additional District General Hospital.

When comparing different scenarios (with and without TST) the potential capital costs breakdown into five categories:

- Minimum costs of backlog repairs & IT enhancements, mostly (77%) at Barts Health
- The re-design and rebuild of Whipps Cross Hospital on its existing site
- Procuring land required for an additional District General Hospital
- The design and build of an additional District General Hospital
- Capital costs of implementing TST.

[5] QIPP is Quality, Innovation, Productivity and Prevention schemes

The costs for doing these are best expressed over either a five or 10 year time frame and are shown in the table below.

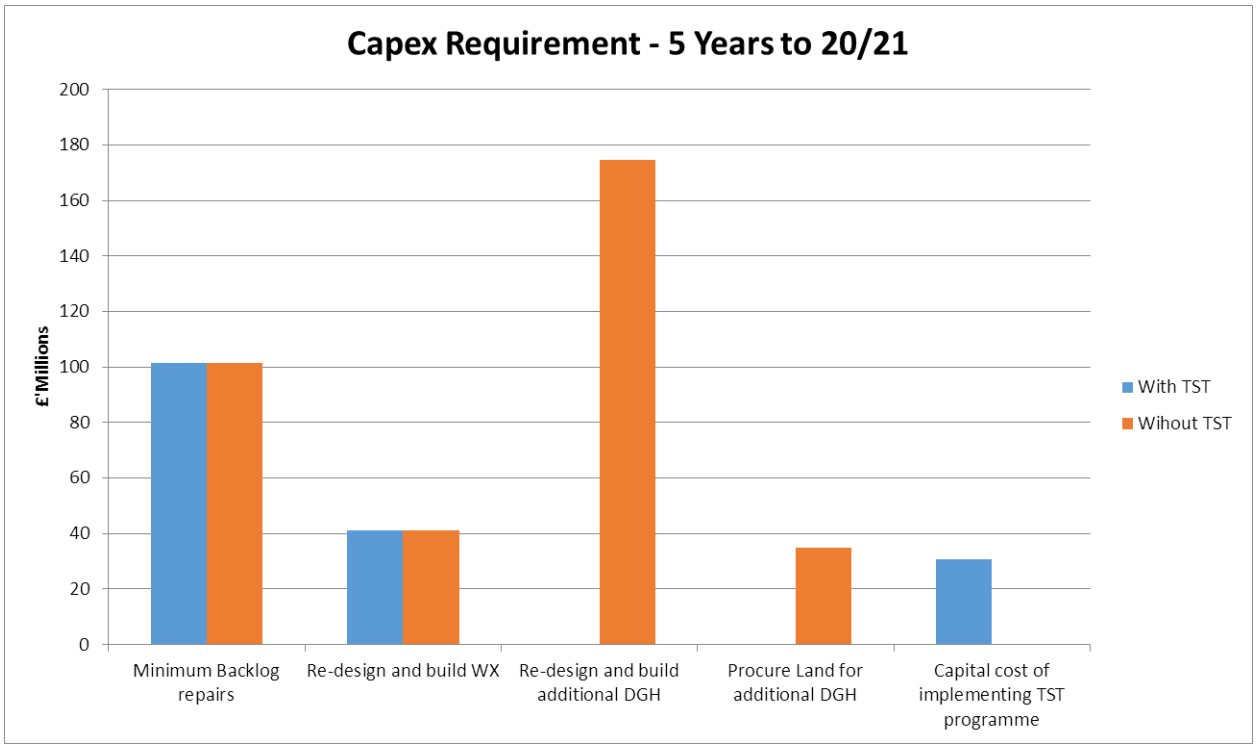


Figure 5: Total Capex over give years 'with' TST is £173m and 'without' TST is £352m

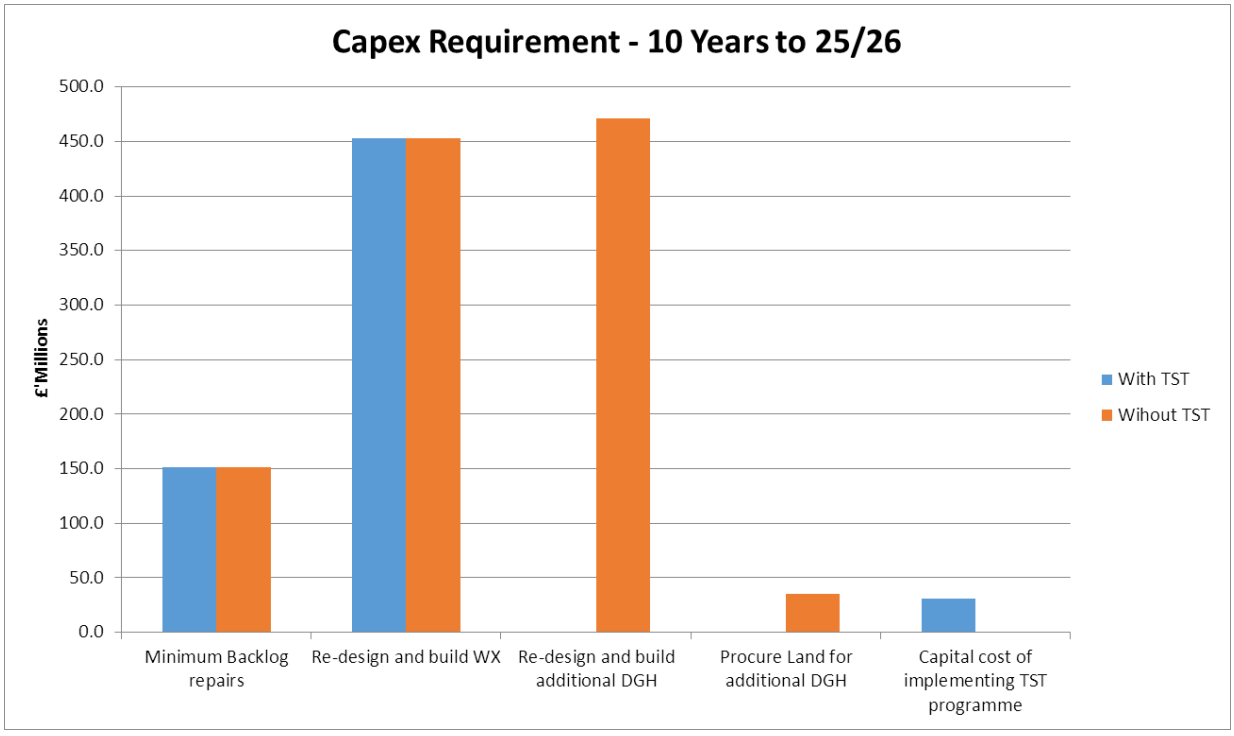


Figure 6: Total capex required by 2025/26 'with' TST is £636m, and 'without' TST is £1,111m

Sources of capital funding

Some smaller areas of the required funding (particularly parts of the TST driven programme) are planned to be sourced from nationally ring-fenced funding streams – most notably the Estates and Technology Transformation Fund. However it is worth noting that this fund is extremely oversubscribed and it is unlikely that WEL will receive a sufficient allocation to progress all of the TST programme requirements.

The principal source of funding for the redesign and rebuild of Whipps Cross Hospital or for an additional hospital should the TST programme not progress, is to follow the traditional process of full business case submission to NHS England.

The national availability of capital funding is extremely limited with much of the Department of Health capital allocation being redirected to support NHS revenue costs in each of the last two years. There are significant programme risks therefore around Barts Health NHS Trust being able to access sufficient capital funding to enable a re-development programme to progress. Any help to support the availability of capital from the submission of the full business case in 2018/19 would be welcomed.

2.6 Bed Base

The growth in demand in WEL is such that over the next five years approximately 440 additional inpatient beds would be required to provide the necessary healthcare activity delivered in its current form.

This is equivalent to an entire additional District General Hospital to be constructed; the cost of doing so (and staffing it) would be prohibitively large. It is anticipated that the application of the TST programme and local QIPP schemes will mitigate the need for many of these beds, allowing the extra capacity to be delivered organically at existing sites without the need for an additional hospital site to be developed.

The table below illustrates the schemes which are intending to affect the bed base requirement. Note that not all TST work streams are intended to reduce the bed base.

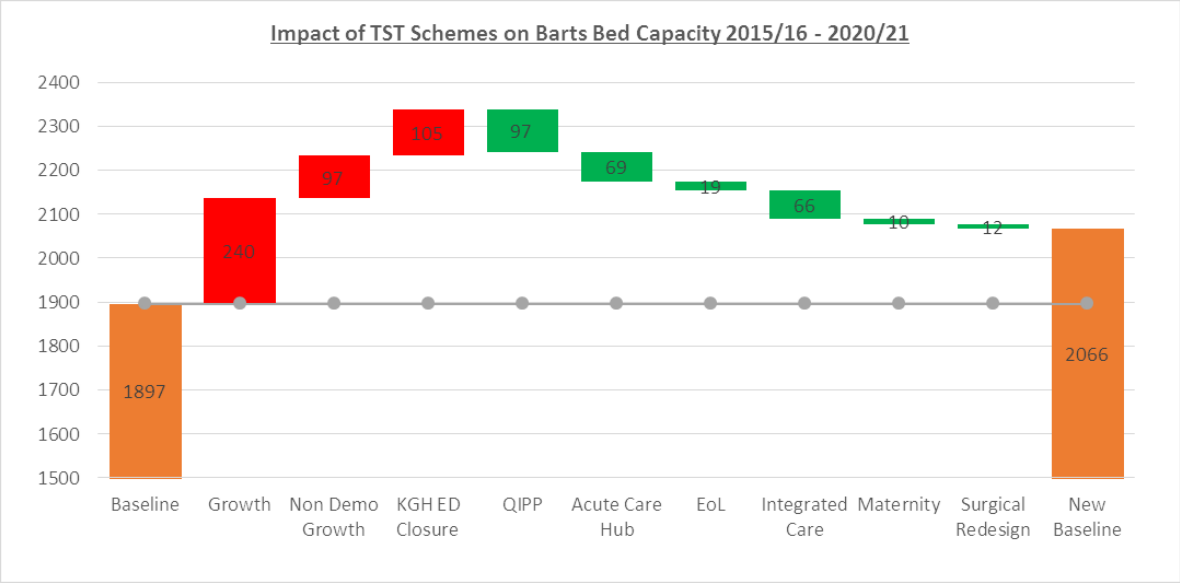


Figure 10 – Impact of TST schemes on Barts bed capacity
N.B. the second column 'Growth' means increased requirement due to demographic growth.

2.7 TST in action – progress

We recognise the efficiency targets are challenging as is managing the flow of people attending A&Es. However WEL CCGs have achieved the required efficiency savings in the last three years and are on track to deliver the 2015/16 target. New schemes in the TST programme (and others) will continue to ensure we achieve our targets. For instance:

Waltham Forest Integrated Care

Population based approach to systematic risk stratification involving community based intervention(s) for adults according to level of need e.g. planned case management; unplanned care rapid response and psychiatric liaison; GP national & local enhanced schemes; care coordination and self-management.

This has achieved an 18% reduction in unplanned hospital admissions in 2015/16 and £2million health savings which have been reinvested in other service.

Tower Hamlets urgent care

This scheme introduced streaming of people attending A&E and a tariff restructure to encourage urgent care centre (UCC) usage. This resulted in A&E attendances being reduced by c14, 000 and savings of c£3million.

East London Foundation Trust community rapid response

Aims to prevent avoidable emergency admissions and readmissions to hospital using short term intensive packages of clinical and social care and a presence in A&E/UCC. The Service works closely with all care homes in Newham through regular visits.

51% of referrals have prevented an admission to A&E.

Reducing unnecessary testing

Local discussions with clinicians (over 100 attended an event in October) agreed that c25% of pathology tests are unnecessary and 20% of primary care initiated MRI requests could be avoided (as per clinical guidance).

In the first two months, enabling and encouraging GPs not to request Gamma GT tests (which have no clinical value in the vast majority of cases) has saved around £54,000. The test is still available but guidance has been developed and circulated to GPs.

Anomalies in the budget spent on AST tests (£1000/year in Newham compared with £400,000 in Tower Hamlets) suggests that sharing good practice would result in significant savings.

These small changes suggest our target efficiency of £5 million a year is achievable.

2.8 Summary

In summary, the increasing demand driven by the existing population and increases in population and the need of that population, cannot be reasonably afforded if provided in the existing model of care and given the expected levels of resource allocation.

In order to continue with the current model of care and cope with this situation, demand would have to be curtailed requiring the rationing of key healthcare services or additional funding would have to be sought from central government. Neither of these options is reasonable or feasible and therefore efficiencies in the delivery of healthcare need to be found.

The acute providers will continue to look for internal cost improvement plans to improve their efficiency in delivering standard items of care, and thereby improve their financial viability.

Commissioners will look to more transformational measures to change the method by which some aspects of care are delivered to move towards more efficient methods.

The Transforming Services Together programme provides an opportunity to significantly improve care provided to our population and will provide a sizeable but not exhaustive proportion of the necessary transformational efficiency measures.

3. Modelling for the primary care workforce

Further published detail can be found in the strategic investment case:

- Part 2 (Main report) page 12: The workforce case for change
- Part 2 (Main report) pages 23-27: Describes the recruitment and retention approaches and discusses organisational development and plans for joint working
- Part 3 (High impact changes): Workforce and organisational development costs are described for each work stream. The physician associate chapter is particularly relevant.

3.1 Introduction

This paper includes:

1. The initial primary care workforce modelling to address the reduction in GPs that was included in the Strategic Investment Case. It also highlights the shifts in activity that underpin the model.
2. Provides an update on specific projects in pharmacy and physician associates and some of the work ongoing in operationalising the workforce model.
3. The initial data modelling that has been carried out by Healthy London Partnership in October 2016 (this is ongoing) and gives an outline of next steps in this process.

The current primary care workforce model was developed in June 2016 and addresses the issues highlighted in the Strategic Investment Case Part 3 (High Impact Changes Page 41). If we do not change our model of care:

- In Newham, Waltham Forest and Tower Hamlets we would require an additional 195 GPs (over current levels) within 10 years if we do not change the way we work and introduce new roles
- Whilst we have examples of good practice, around 40% of those responding to the GP National Patient Survey report they cannot see a GP of their choice and over 30% find it difficult to get through on the phone
- Up to half of practices in some areas are shut at lunchtime
- Patient experience of GP out-of-hours services is ranked one of the worst in England
- Less than a third of the capital's GPs believe they have received sufficient training to diagnose and manage dementia
- We don't have sufficient career development opportunities for GPs and nurses in training
- Some (particularly single-handed) practices are in premises unfit for modern practice
- We do not have sufficient multi-disciplinary teams
- Rising living costs are making living locally almost impossible
- Many outcome indicators (e.g. for cancer survival and support for people with long term conditions) are in the bottom 20% nationally.

Whilst this paper focuses on the model of care and activity in **GP surgeries** it should be noted that TST and other local schemes describe a range of other activities that are intended to support the GP surgery and wider primary care workforce including:

- the development of multi-disciplinary teams
- the development of proactive care which will identify people at risk and diagnose patients more quickly - reducing the burden of disease on both patients and the NHS
- support for helping people to lead healthier lifestyles, support to put patients in control of their own care and to self-care
- shared care records and interconnectivity between primary care and between primary and secondary care - reducing time spent in gaining health histories, reducing the need for repeat tests, enabling people to be treated more quickly and providing more opportunities to access the primary care system
- more opportunities for innovative ways of conducting appointments e.g. online, by telephone or by video - reducing the need for face-to-face services
- the development of federations of practices and hubs which will increase back office efficiency and be able to offer more services in one place
- cross-system recruitment and retention schemes into new and existing careers, to make east London a destination for a highly skilled workforce
- provision of key worker housing
- financial incentives for staff e.g. support with student loans
- flexible working options
- improving career development opportunities.

3.2 Activity shifts and workforce numbers in GP practices

In order to meet the demand within GP practices and the expected reduction in available GPs we will need to shift activity from GPs to other, more appropriate and more efficient roles.

PRIMARY CARE DEMAND							
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Baseline Activity (incl growth)	4,641,745	4,732,256	4,817,936	4,914,155	5,020,515	5,126,353	5,230,997
Shift to Pharm/Com	0.00%	2.96%	4.00%	5.00%	6.00%	8.00%	9.00%
Shift to Self Care	0.00%	1.85%	2.96%	4.07%	5.60%	6.70%	7.41%
TST Shift to 1ry Care	0	0	9,331	53,174	63,507	74,046	84,793
1ry Care Workforce		**2015/16**	**2016/17**	**2017/18**	**2018/19**	**2019/20**	**2020/21**
Activty % to GPs	80.0%	79.5%	74.0%	72.0%	64.8%	61.7%	59.4%
Activty % to nurses	20.0%	20.0%	24.0%	24.0%	26.0%	26.0%	26.0%
Activty % to PAs	0.0%	0.0%	0.0%	0.0%	3.2%	4.3%	5.6%
Activty % to Pharm	0.0%	0.5%	2.0%	4.0%	6.0%	8.0%	9.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL Activity		4,732,256	4,827,268	4,967,329	5,084,023	5,200,399	5,315,790

Table 1: Activity Shifts within (and from) GP practices. June 2016-2021

*Pharm/com is activity shifting to pharmacists in the community and other community-based staff.

The model describes a shift of activity to Physician Associates (PAs) and Pharmacy and Community Workers where (in 2021) GP activity is reduced by 20.1%. This reduction is made up by an increase in activity taken on by nursing of 6%, Physician Associates 5.6%, and Pharmacy of 9%.

The model integrates the activity described above with the number of staff required:

- using a baseline for activity within GP practices as 80% for GPs and 20% for Nurses (including administration and clinical duties).
- using efficiencies based on local statistics and tested locally with clinicians including a 26% reduction in 'Did Not Attend' (DNA) rates (which waste GPs time) over five years – to be tackled by quality improvement initiatives such as text reminders, more proactive care and better management of the issue
- building in an increase in the number of 'longer appointments'
- using data from focus groups that has shown that around 30% of the GP workload can be transferred to other health and social care professionals (e.g. treating coughs and colds)
- using national data that indicates that around 11% of a GP's time is spent on administrative tasks such as filling in data returns.

The data shows that an additional 81 clinical staff and 23 administrative staff would need to be in place in GP surgeries to meet the activity shifts set out in Table 1. We are already building the supply for physician associates and pharmacists to meet this challenge.

Staff Required - Post TST productivity/efficiency savings	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	Change from 2015-16
GP	601	559	532	477	454	445	-156
Nurse	158	206	211	214	207	220	+62
PA	0	0	0	24	33	44	+44
Pharmacist	4	16	33	49	65	73	+69
Locum	0	0	0	0	0	0	0
Admin	133	134	135	137	137	138	+5
Community	25	35	45	55	75	87	+62
Senior Admin	0	4	7	11	14	18	+18
TOTAL	921	954	964	967	986	1025	+104

Table 2: GP Surgery Workforce Modelling June 2016-2021 based on activity shifts in Table 1 and efficiency savings

*Due to different data extractions, 'Community' currently includes healthcare navigators, medical assistants, physician associates etc but in later years physician associates have their own line.

3.3 Healthy London Partnership (HLP) Modelling

We have been working with Healthy London Partnership (HLP) across Waltham Forest, Newham and Tower Hamlets and had two initial workshops in October 2016 to build on the existing workforce modelling.

This process builds on national data and, working with local clinicians, we will model current efficiencies and those being proposed; and then look at how these ways of working can be used to introduce new roles or reassign roles to reduce workforce gaps. Initial efficiencies include the use of telephone appointments and benefits in practices that have multi-disciplinary professionals.

The initial modelling from HLP with a 'do nothing' plan shows a consistent picture with the TST modelling. By 2021 if we do nothing we will have a shortage of 122 GPs. Assumptions made are that 15% of GPs over 55 will retire by 2021, (29% of GPs are aged 55 and over), a population increase in WEL of 76,000 to 2021 (8%) and that we recruit available GPs in line with current London levels.

Analysis shows a gap in the nursing workforce required if we do nothing and this gap is likely to increase as in Waltham Forest 52% of the workforce is over 55 and in Newham 43% of the workforce is over 55.

HLP has highlighted significant differences in baseline numbers of staff across the TST footprint. Tower Hamlets has a lower than the national average of patients per GP and nurse, but Waltham Forest and Newham have higher numbers of patients per GP and nurse.

3.4 Training posts and careers

Work is ongoing to map and review training posts and pilot posts to see where training takes place. The data suggests that to deliver a sustainable model we will need to encourage mid-size and smaller practices to provide training as well as large practices to build sufficient capacity and a system to train the workforce of the future.

We are working with colleges to encourage careers in health and build pathways into new roles. We are developing a careers and jobs portal to signpost job seekers to posts and career pathways available in the CCGs.

3.5 TST in action – progress

Physician associate at Allum Medical Centre

Allum Medical Centre in Waltham Forest has used a physician associate as part of a range of innovative changes to the way practice staff are working. By sharing the workload the practice can see more patients. The physician associate sees more than 100 patients a week so the patient list size has increased by more than 1,000 without the need to employ more GPs. The practice offers up to 120 same-day appointments each day.

Physician associates programme

The business case was developed in January 2016 to move this project forward and a steering group and a clinical lead appointed. A new curriculum for a physician associate (PA) role in primary care has been developed (other PA roles have been successfully based in secondary care).

- Recruitment is taking place in November 2016 with students starting the two year course in January 2017.
- The CCGs have agreed a matched funded sponsorship arrangement for the first cohort of 24 students for second year fees on successful completion of year 1.
- An engagement event with GPs across TST in September 2016 to discuss the placement and training requirement for physician associates resulted in all 24 placements being filled with an even split across the three boroughs.
- In conjunction with GP practices we are developing posts for successful candidates.

In addition we are looking at developing alternative methods of training to give future cohorts different options to undertake training. Twenty GPs in the TST footprint have signed up as prospective employers to start development of a higher level apprentice standard for physician associates. We will explore different funding streams from Health Education England and providers as this system develops from April 2017 which could allow us to have a flexible employment and training model to sustain the role, and multi- disciplinary teams in primary care across TST.

Pharmacists in GP practices

We have a three year pilot funded by Health Education England (HEE) of 13 pharmacists in Newham GP practices. Further funding has been made available from the GP Five Year Forward View to increase numbers for April 2017. Feedback from practices in the pilot is that this role allows GPs to increase clinical time.

We have two events in November to promote new ways of working and for community pharmacists to shape working practices and roles in GP practices and primary care.

We will be introducing a rotation scheme for pre-registration pharmacists into primary care and GP practices, and an agreed discharge pilot scheme for pharmacy to support patients with respiratory, diabetes and cardiovascular problems. Both schemes are scheduled to start in April 2017 and will see pharmacists working with patients from secondary to primary care.

Practice nurses and support within GP surgeries

We have 26 GP practice nurses in training posts in Newham, Tower Hamlets and Waltham Forest. The Community Education Provider Networks (CEPN) are co-ordinating work to retain nursing staff in the area from this cohort. Recruitment for the January 2017 intake is ongoing through the CEPNs for similar numbers of nursing staff.

There are two other initiatives to build the nursing multi-disciplinary workforce:

- A nursing pilot for rotational nursing posts between acute and primary care will be recruited to – for commencement in January 2017.
- North East London Foundation Trust (NELFT) has just been selected as a pilot site for new nursing associate roles. These posts will start in early 2017 and be based in secondary care (at NELFT), with placements in primary care to be developed.

3.6 Summary

In order to meet the shortfall of supply of GPs in NEL, (high retirement rates and a shortage of available new GPs) and to develop a more efficient, patient-centred service, we will need to develop and increase the numbers of practice nurses, physician associates and pharmacists to provide a full multi-disciplinary team (MDT) workforce model. We are currently on target to deliver physician associate training placements in 2017 and a workforce supply in 2019. We have a pharmacist pilot programme in Newham GP practices and will look to expand this across TST in 2017-18.

This, combined with ensuring that we continue to develop and deliver portfolio careers and flexible employment options for GPs, will allow us to develop our multidisciplinary teams in GP practices.

Transforming Services Together

Report to the Inner North East London Joint Health and Overview Scrutiny Committee

7 November 2016

Context

Agenda agreed with JHOSC chair and vice-chair at a meeting with CCG chief officers

7 November

- Introduction
- Financial implications
- Workforce implications

17 November

- Self care
- Elective care
- Movement of services and patient journeys

Transforming Services Together

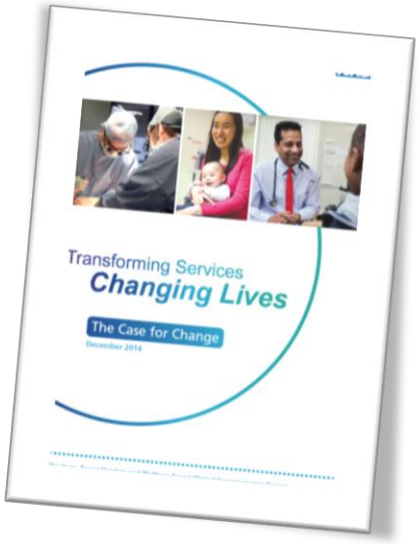
- A partnership between Newham, Tower Hamlets and Waltham Forest CCGs and Barts Health NHS Trust but involving multiple other organisations and stakeholders
- Aims to address challenges that are best tackled in partnership (rather than individually) and deliver safer, more sustainable, high-quality services to improve the local health and social care economy in east London

The case for change

Our population is growing rapidly: we expect another 270,000 people on top of the existing 861,000 over the next 15 years

Without change, this would:

- Require over 25% (550) more beds and 1 million more primary care appointments
- Burden us with a £400m+ shortfall
- Continue the variable quality of care (some world class services, but also significant challenges)
- Fail to address life expectancy and health inequalities challenges
- Result in continued workforce challenges

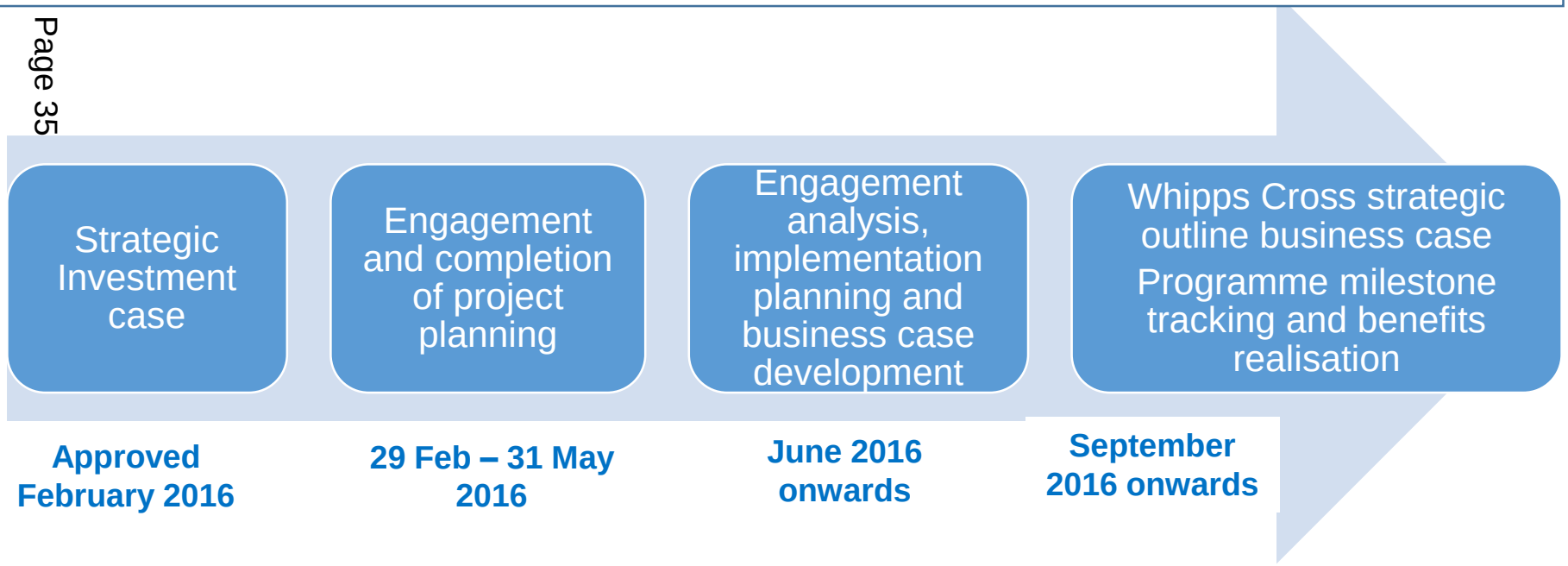


Because of population growth and growing demand, closing an A&E/maternity unit is not an option. Building 550 beds is not an option either. We need to manage with the existing bed base

Timeline

The TST programme will:

- ✓ plan across the health system and geographical area for the future
- ✓ work collaboratively to provide integrated and coordinated care – patients move across boundaries
- ✓ focus on system savings and joint accountability: moving away from which organisation or borough ‘wins/loses’



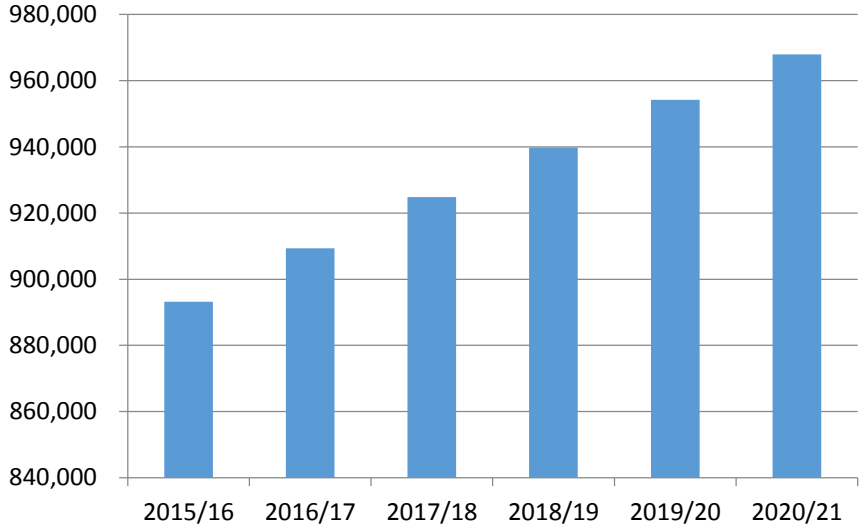
Summary of Financial Implications

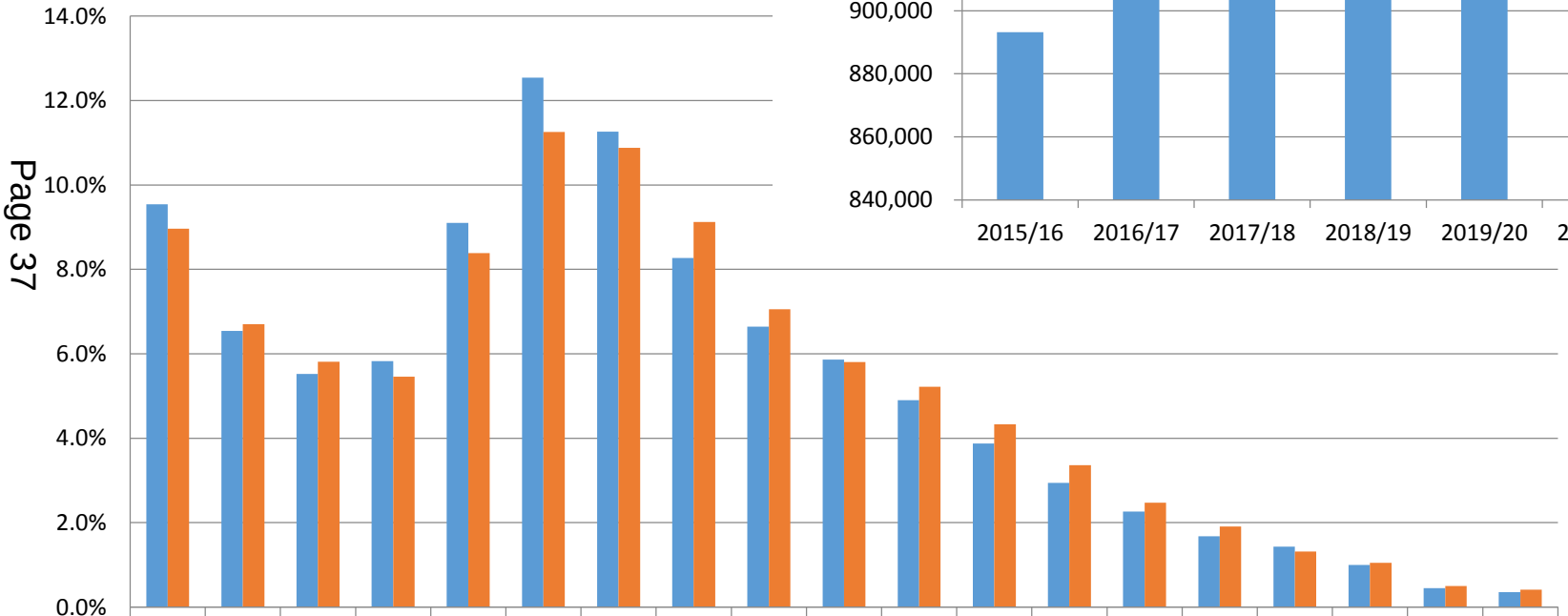
Demand growth

As the population grows and ages, the demand for health care increases.

Population projection

Age of population

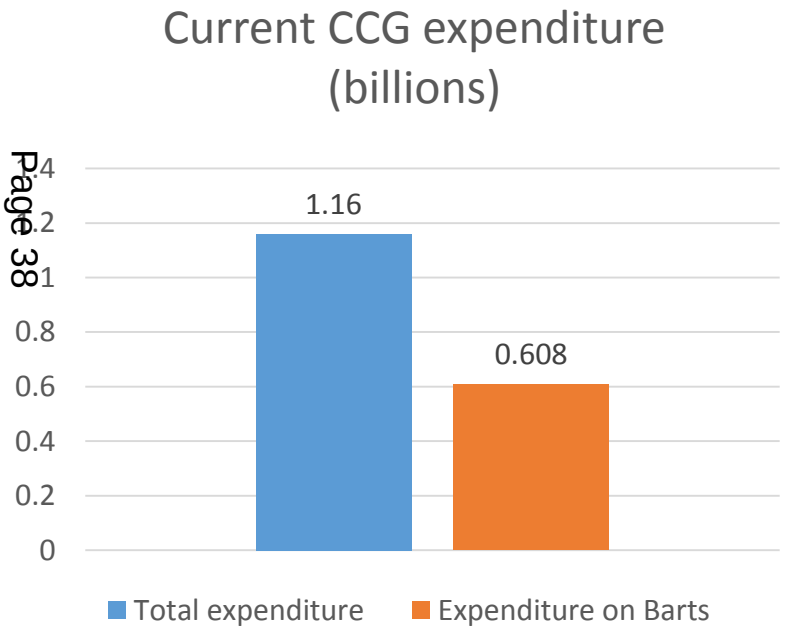


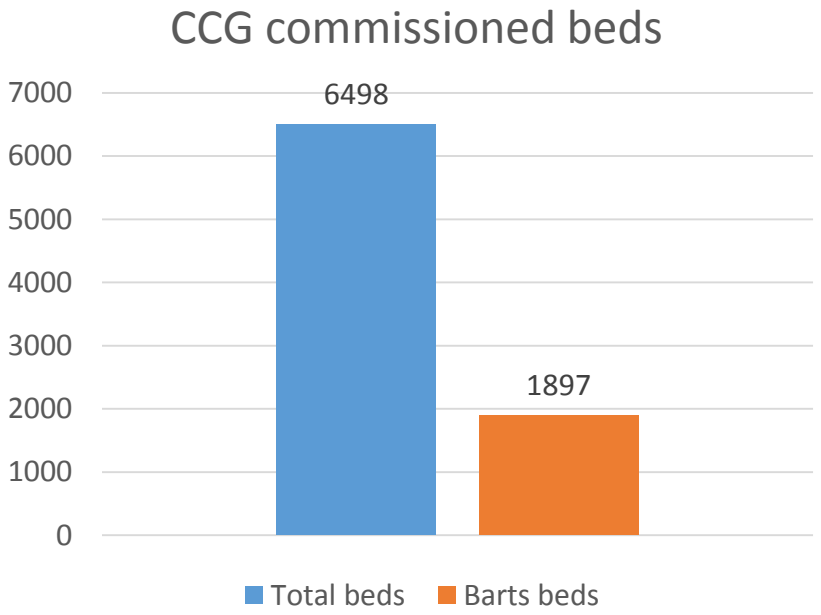


	0-5 Years	6-10 Years	11-15 Years	16-20 Years	21-25 Years	26-30 Years	31-35 Years	36-40 Years	41-45 Years	46-50 Years	51-55 Years	56-60 Years	61-65 Years	66-70 Years	71-75 Years	76-80 Years	81-85 Years	86-90 Years	90+ Years
2015/16	9.5%	6.5%	5.5%	5.8%	9.1%	12.5%	11.3%	8.3%	6.6%	5.9%	4.9%	3.9%	2.9%	2.3%	1.7%	1.4%	1.0%	0.4%	0.4%
2020/21	9.0%	6.7%	5.8%	5.5%	8.4%	11.3%	10.9%	9.1%	7.1%	5.8%	5.2%	4.3%	3.4%	2.5%	1.9%	1.3%	1.1%	0.5%	0.4%

WEL CCG current income, expenditure and beds

Total current annual WEL CCG expenditure is £1.16bn (£608m with Barts). WEL CCGs income is roughly equal (CCGs are currently projecting a small surplus in 2015/16).

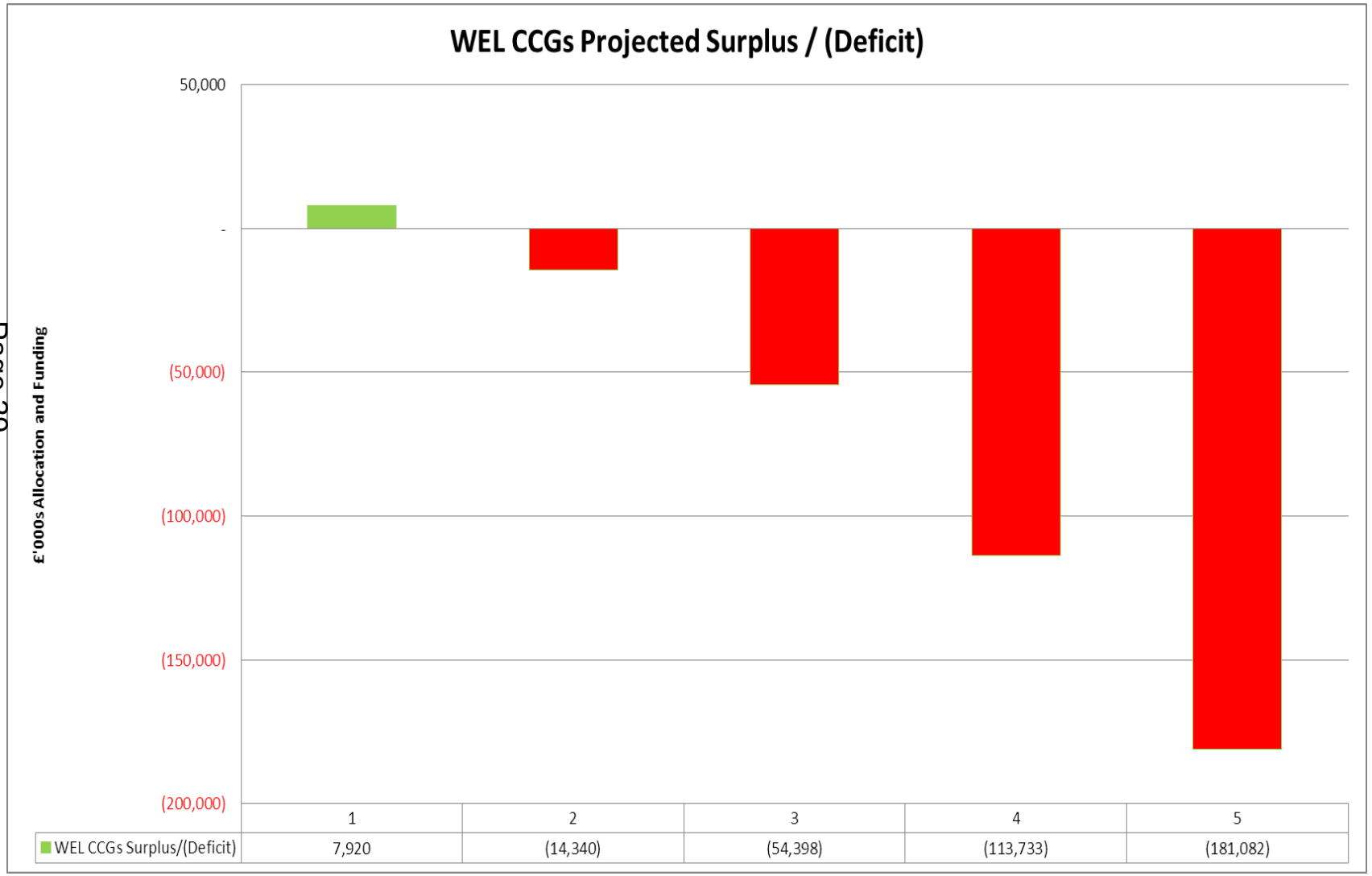




Expenditure provides a current bed base of 6,498 across acute, community care, primary care and mental health sectors. Barts accounts for 1,897 (29%) of the total beds.

WEL CCGs projected surplus/deficit

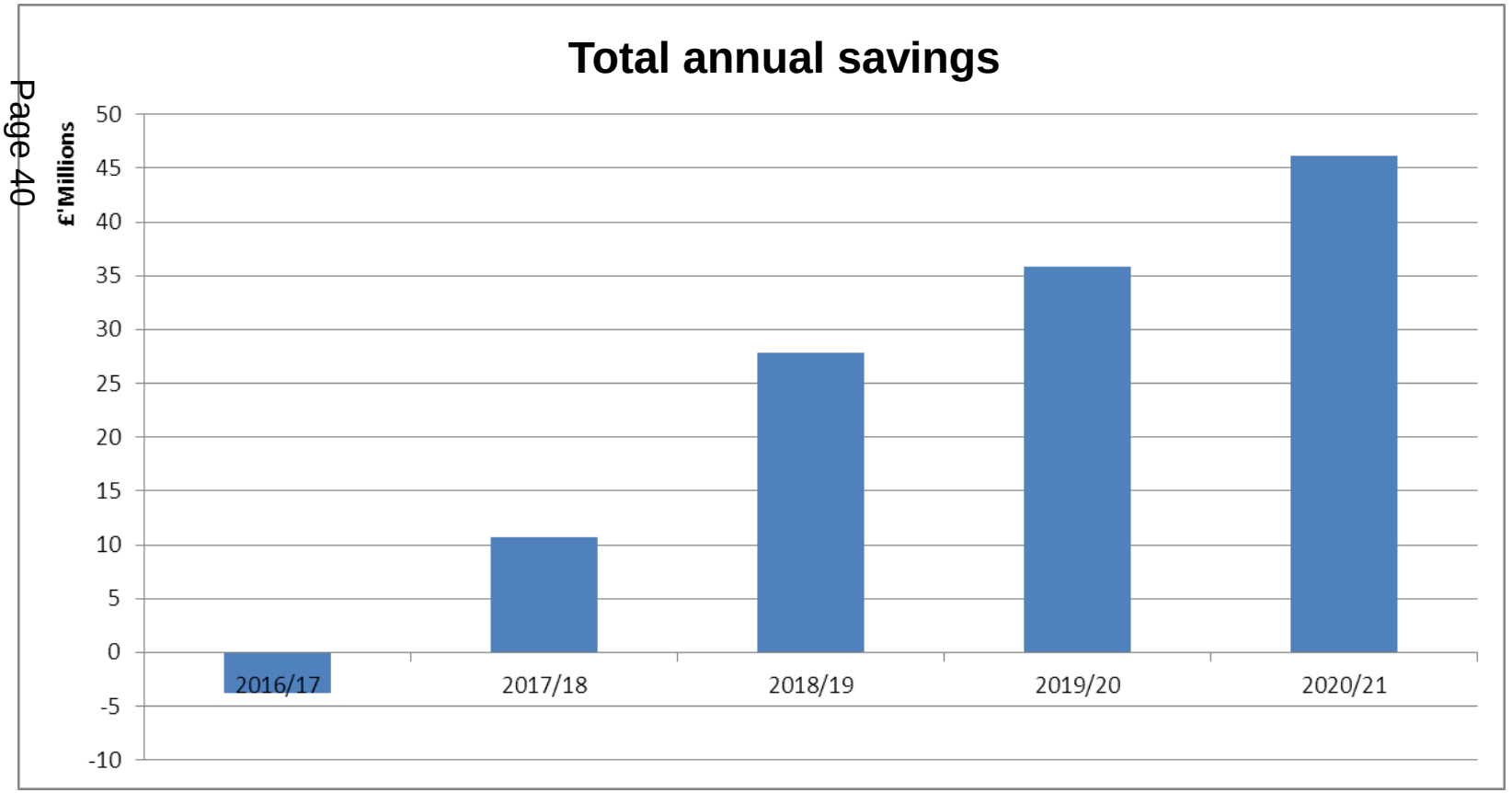
We anticipate a 20% increase in costs by 2020/21 and a need to invest in a range of schemes. When these are taken into account along with an income increase of c£142m there is a shortfall of £181m a year.



TST savings contribution

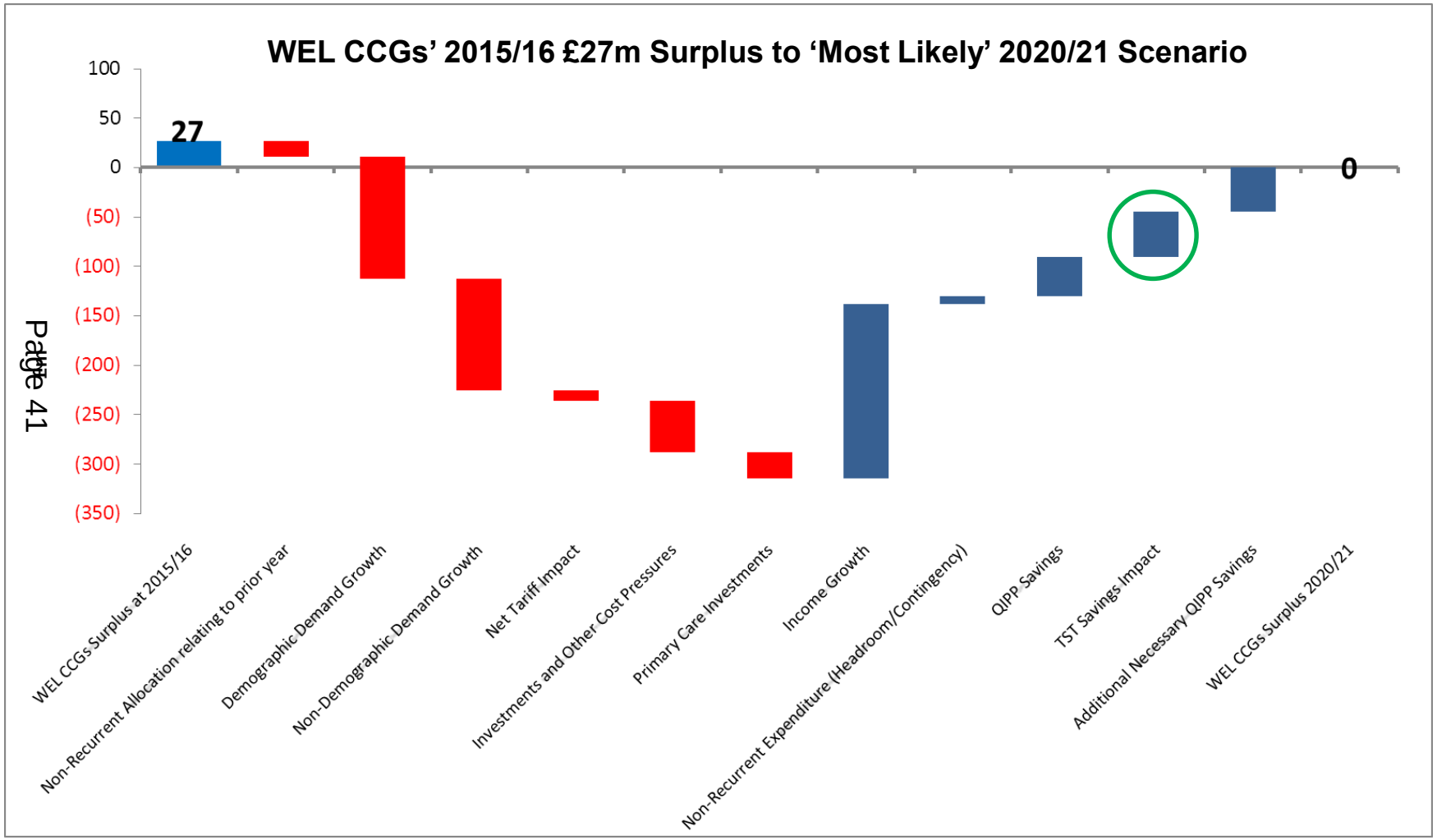
The TST programme seeks efficiencies through 12 projects (workstreams) which are felt to have the largest possibility of delivering savings and/or provide the biggest patient experience and outcome gains.

The 2020/21 (recurrent) saving is forecast to be £46.2million



TST contribution to total sustainability programme

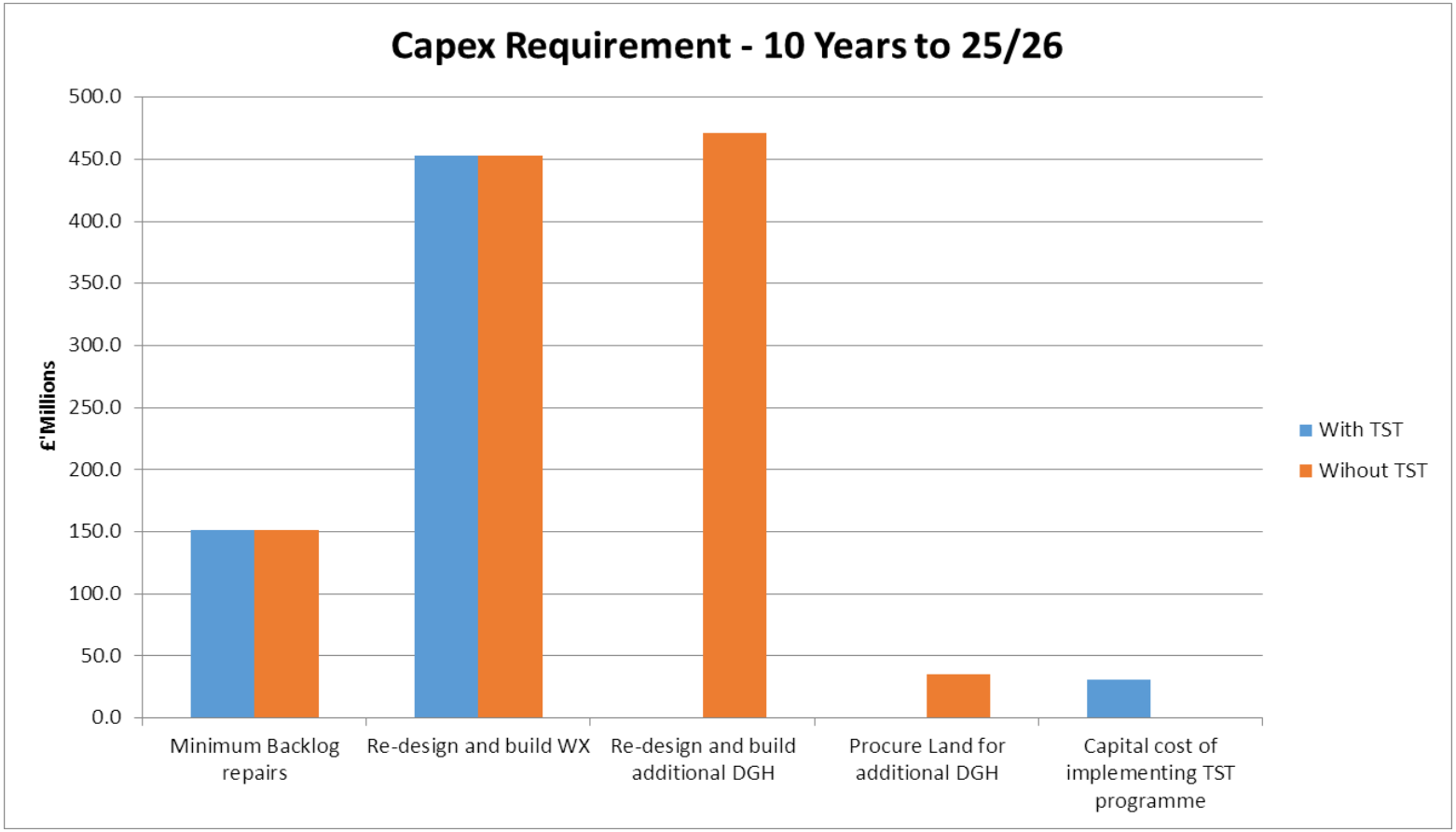
The chart below shows the bridge between the 2015/16 outturn and the planned position for 20/21. TST is a small, but important part of the recovery.



TST capital requirement and contribution

The chart below shows the difference TST makes to capital requirements. By 2025/26 'with' TST the requirement is £636million. 'Without' TST the requirement is £1,111 million.

National availability of capital funding is limited, so £636million will be a challenge.



Provider perspective: Barts Health

Barts Health is forecasting a £82.7million deficit for the year.

This presentation primarily explains the CCG financial challenges and opportunities. However Barts Health is a full partner in order to ensure:

- the trust takes advantage of any opportunities arising (e.g. surgical services, shared care records and capital requirements)
- we work together to agree and plan changes so the trust has the best opportunity to eliminate or reduce any stranded costs (e.g. diagnostics and outpatient transformation)
- there are no unintended financial consequences on the trust.

TST forecasts that the size of the Barts annual deficit will decrease slightly over the coming years driven by:

- increases in tariff prices paid per unit of activity
- achievement of internal cost improvement plans associated with TST.

By 2020/21 the annual provider deficit is expected to be c£46million, albeit with a significant accumulated deficit. This annual deficit is roughly the same size as Barts' estimated PFI-related excess cost: a key point in our discussions with the Department of Health and NHS England.

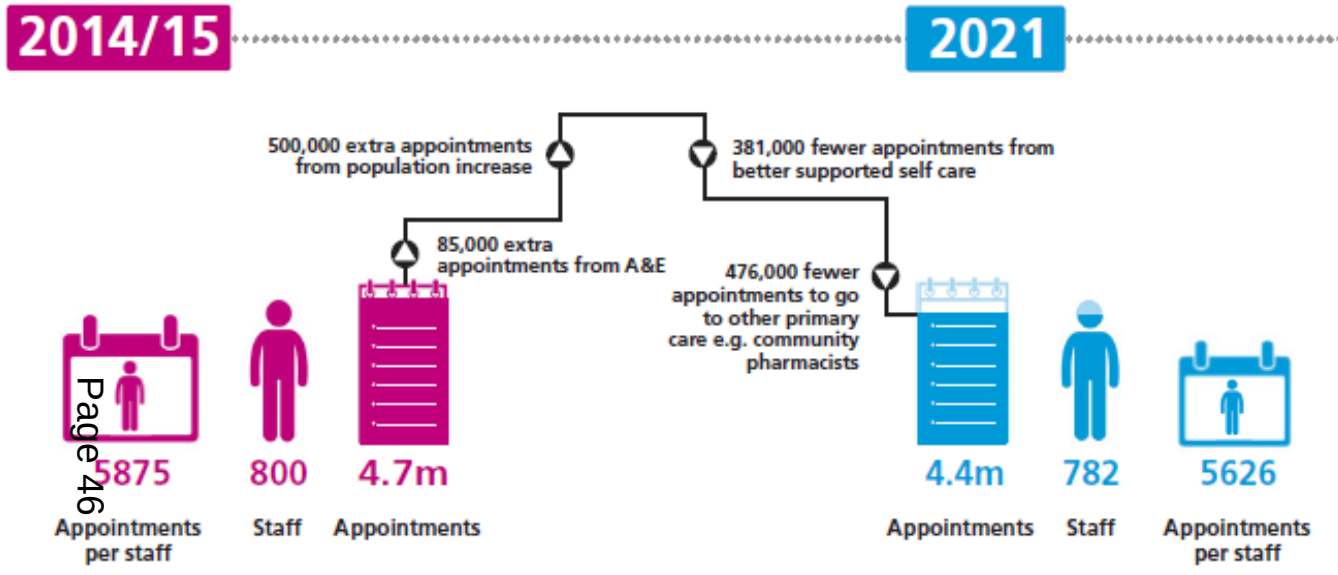
Improving patient experiences and outcomes whilst achieving financial sustainability: progress

The WEL CCGs have achieved challenging efficiency targets in each of the last three years and are on target to deliver this year. Sample schemes…

Scheme	Description – what is working well	Outcomes
Reducing unnecessary testing	• Worked with clinicians (over 100 in October) • 25% of pathology tests are unnecessary and 20% of primary care initiated MRI requests could be avoided if latest clinical guidance is followed • Gamma GT test routinely ordered with a bundle of 7 liver function tests. By 'unbundling' the tests and providing guidance to GPs, usage has plummeted	• £54k saving on Gamma GT test alone in two months • AST test identified £500k/yr savings too • Workstream is seeking other gains
Waltham Forest Integrated Care	• Identifies adults at risk and puts in community-based intervention(s) e.g. planned case management; unplanned care rapid response and psychiatric liaison; GP schemes; coordinated care; self management and third sector support	• 18% reduction in unplanned hospital admissions 2015/16 resulting in £2million savings reinvested
ELFT community rapid response	• Presence in A&E and inreach in care homes aims to prevent avoidable emergency admissions and readmissions to hospital using alternative short term intensive packages of clinical/social care	• 51% of referrals have prevented an admission. Now integrated into community nursing
Tower Hamlets urgent care	• GP streaming of patients in A&E and tariff restructure has incentivised urgent care centre usage	• Reduced A&E attendances by c14k, saving c£3million.

Summary of workforce implications

Appointments and workforce in GP surgeries



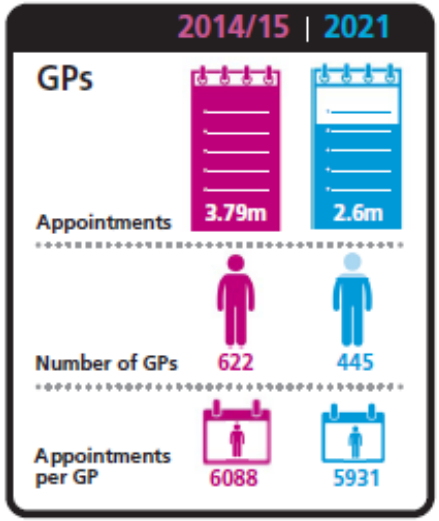
GP efficiency improvements

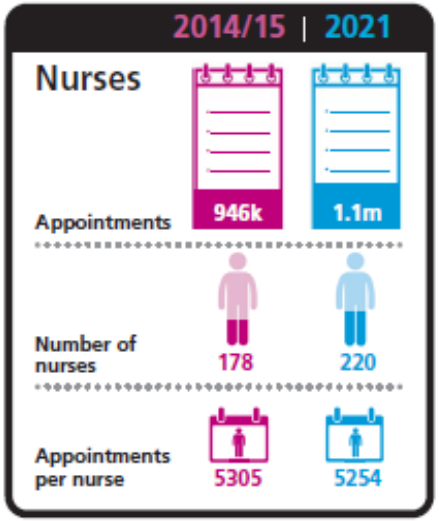
Currently GP's spend only about **62%** of their time on effective clinical work.

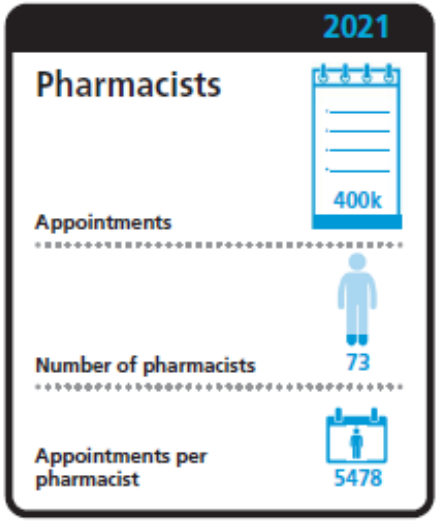
Around **18%** of their time is spent on bureaucracy e.g. Reporting and claiming repayments.

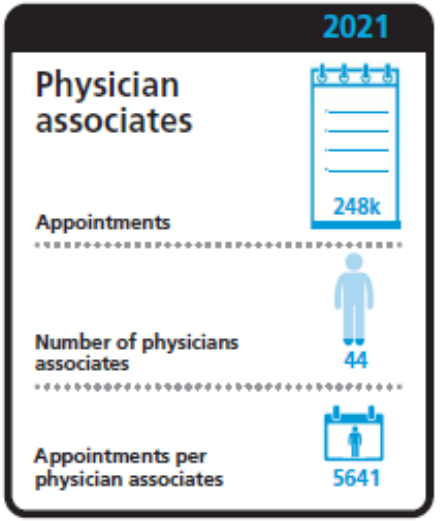
20% of their time is spent on advice and treatment for common illnesses.

If efficiency was increased to **85%** we could offer **220,000** longer appointments and cope with thousands more appointments.









NOTE: This graphic does not account for an increase in community staff (care navigators, medical assistants etc) based in GP surgeries. This cohort is expected to rise from 25 staff to 87 (an increase of 62).

A primary care workforce fit for the future: progress

Scheme	Description – what is working well
Physician associates in GP practices	• Allum Medical Centre in Waltham Forest employs a physician associate as part of a diverse workforce. The practice offers up to 120 same-day appointments every day. The physician associate sees more than 100 patients a week. Patient list size has grown by more than 1,000 without needing more GPs • 24 students start a two year course in Jan 2017 at Queen Mary. CCGs have agreed match funding for 2nd year fees and practices have agreed to take all placements (33 trainees planned for 2018) • Currently developing the detail of posts • New methods of training being explored (e.g. apprenticeships)
Pharmacists in GP practices	• 3 year pilot funded by HEE of 13 pharmacists in Newham • Feedback positive – leads to increased GP clinical time • Developing a scheme to promote links between community pharmacists and GP surgeries and a discharge scheme to support patients with long term conditions

A primary care workforce fit for the future: progress

Scheme	Description – what is working well
Practice nurses	• 26 practice nurses in training – developing strategies to retain them • Pilot scheme for nurses to rotate between acute and primary care which will increase understanding and improve coordination • NELFT selected as pilot site for new nursing associate roles with placements in primary care
Promotion and marketing	• Aims to promote east London as a destination for GPs, healthcare assistants, allied health professionals, pharmacists etc • Planning to run recruitment fairs; to link with colleges and schools and with housing associations and other partners • Seeking funding to employ a project manager. Investigating housing and travel cost issues with London group