



Transforming Services *Changing Lives*

The Case for Change

December 2014

About this document

This document is part of a library of materials that will be used to develop and improve health services in east London. Other materials include the interim *Case for Change*, videos, clinical working group reports and data packs. You can find these at www.transformingservices.org.uk or get a paper copy by emailing us at tscl@nelcsu.nhs.uk or phoning 020 3688 1678.

This document echoes the interim version, but we have changed it a lot after feedback. Clinical working groups have reviewed all the feedback and, in the light of their own experiences, agreed reports that will form the building blocks of future local NHS planning. Of course the document is never really 'final'. We can plan for the future but political, environmental, economic, social and technological changes make it uncertain. The NHS will need to react quickly to new knowledge, policy and developments. However, this blueprint for change has much support from patients, the public, stakeholders and staff. We will continue to discuss and reshape our ideas and proposals. So if you are part of a community group or organisation, we would be happy to send a representative to a meeting to explain and discuss our progress.

In developing this *Case for Change*:

- We have taken information about the population's health from several sources, in particular the Office of National Statistics and the HSCIC (Health and Social Care Information Centre). This information is consistent with joint strategic needs assessments published by each borough's public health director.
- Projections of population growth have come from the Greater London Authority (SHLAA-capped model 2013 release). Borough public health directors have agreed they are the best available.
- The clinical working groups considered the best available local data on current performance and activity from local providers and national sources. Providers' different coding and submission practices will always mean there are limitations to this data.
- We have used data from different sources over different time periods. In addition, different geographic areas are more relevant for different services. We have used the following geographic descriptors:
 - **East London** describes the boroughs of Newham, Tower Hamlets and Waltham Forest. This area is the focus of this case for change
 - **North east London (NEL)** describes the City of London and the boroughs of Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest
 - **Waltham Forest, east London and the City (WELC)** describes the City of London and the boroughs of Hackney, Newham, Tower Hamlets and Waltham Forest
 - **East London and the City (ELC)** describes the City of London and the boroughs of Hackney, Newham and Tower Hamlets.

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Other materials including all the clinical working group reports and data packs can be found at www.transformingservices.org.uk or by emailing us at tscl@nelcsu.nhs.uk or phoning 020 3688 1678.



Foreword

The NHS in east London faces a huge challenge. Birth rates and A&E attendances are rising rapidly with the growing population; health services need to improve; but an overall financial deficit remains. We cannot afford to carry on as we are. Cancer waiting times, referral-to-treatment times and A&E waiting times are the subject of many newspaper headlines because patients really care about them.

In recent months the *NHS Five Year Forward View*¹; *Better Health for London*²; and *Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care*³ have all advocated significant change in the way the NHS works.

Simon Stevens, NHS Chief Executive, recently told the Royal College of General Practitioners, "GPs themselves say that in many parts of the country the corner shop model of primary care is past its use-by date. We need to tear up the design flaw in the 1948 NHS model where family doctors were organised entirely separately from hospital specialists and where patients with chronic health conditions are increasingly passed from pillar to post between different bits of health and social services."⁴

There is a clear case for change, not just to improve existing services, but to ensure that health and social care in east London tackles the continuing difficulties we face and takes full advantage of opportunities to improve.

The NHS in east London wants to be bold, and must be bold, to make a difference and to be sustainable. There are work programmes tackling immediate issues, but *Transforming Services, Changing Lives* seeks to solve their root causes:

- It is far more efficient and effective to prevent ill health and treat people holistically by looking at their physical and mental health needs together.
- There are tremendous opportunities to care for more people in their own homes and support them to be healthier. We can use technology to make appointments through the internet. We can use pioneering robotics to do complex procedures more safely, with ever-improving outcomes. But we also need to get the basics right. We can talk about offering outpatient appointments via Skype at the evening or weekend. But first we need to organise services to prevent patients receiving their appointment details only the day before (or sometimes after) their appointment.
- We need to integrate care and design new, more efficient care pathways so that patients experience joined-up, responsive health and social care services.
- Where there are clear advantages in co-locating some specialties we should do so. Where estate (e.g. buildings) is not being used effectively, we should develop alternatives.

1 NHS England (2014): *NHS Five Year Forward View*

2 London Health Commission (2014): *Better Health for London*

3 Association of Medical Royal Colleges (2014): *Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care*

4 2 October 2014

We do not need to choose between making efficiencies and improving care. We can create a virtuous circle. We can have our (low-calorie) cake – and eat it.

We thank the 350 clinicians across east London and almost 3,000 members of the public, patients and other stakeholders who took time to help us develop ideas for change. In particular we would like to thank Healthwatch, local councils, clinicians and members of the patient and public reference group (PPRG) for their time and effort. Members of the PPRG have recorded their views on video (see our website⁵) and developed the very clear patient perspective that follows this foreword.

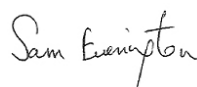
We feel strongly that this *Case for Change* provides the basis for higher-quality, more efficient and joined-up care in east London.

Organisations need to work together to create change across the whole health care system. So the *Transforming Services, Changing Lives* programme, which was established to redesign hospital-based care, will fit into a wider programme of improvements across the whole range of health and social care. These improvements are summarised at the end of this document and in our joint *Five-year Strategy*. Our delivery programme is called *Transforming Services Together*.

Continuing this work will mean that health and social care systems will work together to improve the population's health and secure high-quality sustainable services for staff, patients and taxpayers – as the people of east London expect and deserve.



Dr Zuhair Zarifa
Chair, Newham CCG



Dr Sam Everington
Chair, Tower Hamlets CCG



Dr Anwar Khan
Chair, Waltham Forest CCG



Dr Steve Ryan
Executive Medical Director
Barts Health NHS Trust



Dr Clare Dollery
Deputy Medical Director
Barts Health NHS Trust

The patients' perspective

We are your patients. Some of us are also carers. Many of us have family responsibilities; and perhaps we work full-time. Some of us have alternative lifestyles and dodgy tastes in music. We struggle, we smile, we have good days and bad... but on the whole we love living in London. We have a lot of things happening in our lives, of which our disease is only one part. We'd like to fit the disease around our life and not let our life be dominated by it. The less time we spend in hospital, the better off many of us will be. This will save the NHS money – so surely that is good for you as well.

While in bed we have time to notice the little things like call alarms not being answered and the lack of drinking straws. In 20 years' time, we won't remember the name of the doctor who treated us, but we will remember the paint peeling off the ceiling above the trolley where we had our first general anaesthetic.

We know you want us to check our post every day for that elusive appointment letter and for us to travel across London from work in the middle of the day, and sit for an hour in a waiting area so the doctor can say the scan was all clear and you can go home now – but what a waste of time. Did a doctor really need to be the person to tell us something so simple?

We notice the Blu-Tack on the walls and the broken chairs and toys to entertain children. When we do spot a clock on the wall it rarely tells the time accurately and the haphazard pile of folders behind the reception desk is not confidence inspiring. We all notice the lack of ownership, the out-of-date notices, the missing information leaflets and drinks machines not working. It seems very odd that when we just want to buy a snack we usually have to cross a dangerous road to do so as nothing is open or available in the hospital.

We are individuals with diseases that other people have, but that doesn't mean we all have to follow the same process. People's individual circumstances are different from everybody else's with the same disease. Some of us live close to the hospital, so you don't need to admit all of us the night before and occupy scarce beds.

We think you are doing a great job on the medical side, but we can't be sure of that, and when our big folder of notes goes walkabout we do worry. When people in the NHS talk about faxing things most of us get confused; some of your younger patients have never seen a fax.

We notice when signs are confusing because it takes three times as long to get somewhere and we have to visit three places to work out where we should go. Using 'Lift Core 5' to get to the fifth floor is just confusing. Sometimes the little things are the easiest to fix.

When we have to help our elderly relatives get treatment, why do we have to visit our local GP and multiple hospitals and trudge for miles? Whipps Cross Hospital (shuttling between different ends of a never-ending corridor); the Royal London (going inside for some treatments and then outside for others); or Barts (up and down the stairs). When we talk to other patients we notice the similarities in our treatment more than the differences: the missing MRI scans, the cancelled appointments and the differences between what the GP says and what the hospital says.

So what do we want from the NHS?

We know you are under strain, but we also suspect you could do some things better for very little money. The world is changing, technology is ever changing. Believe it or not, the less we have to see you, the happier many of us would be. Anything you can do to speed things up and keep us out of hospital is good for everyone; and when we email PALS we do hope one day for an answer.

As patients we would like to see a sense of ownership of the place you work in. Is that sign pointing in the right direction? It only takes a second to fix. Perhaps a smile or a cheery 'Good morning' when you first enter a ward; we will notice.

- We are comfortable at home. Many of us can arrange the rest of our life over the internet from home so why not manage our health as well? If you ask us to do tests at home, we'd be happy with that and then when we really do need to see somebody face to face you'll have more time for us.
- Sometimes we'll need all your help and support. Hospitals can be scary and we'll need more time and understanding. You will have to use your skills and judgement about when those times will be.
- One day, maybe at lunch, just wander around the place you work in. Try to switch off the medical side of your brain and imagine you were in a hotel or shop; would you be impressed by what you see? If not, why not? What could you fix in minutes? The sooner you start, the sooner you'll finish. These are the things we notice and remember. Because they appear to be so simple to fix, we wonder why it has not been done already.
- If you ask us for information or to fill in a survey, it would be nice to hear back from you. And please make your feedback and complaints system easy to access.
- Treat the whole person not just the different bits – my body and brain are connected. The treatment of different parts of our bodies involves different doctors, which we can understand... but why so many different buildings?
- Think about those long commutes across London that your patients endure (traffic in east London is only going to get worse). Could you spend one day a week in another location or could you call or email somebody if the news is simple? Does it even have to be an expensive doctor who writes the email or makes the phone call? Most questions do not require a doctor to answer.
- It would be good to have a sense that there is a planned journey for us through the healthcare system; that you know what the steps are, but that they are flexible enough to suit us as individuals.
- Longer opening hours, more flexibility to speed things up. Many people are happy to work Saturdays if they can get time off in the week, but many patients do not have that choice.
- The East End is a building site as new homes are created in the old dock areas, Aldgate or Stratford. Its physical shape is changing, its population is changing as well so you'll need to plan better to stay on top of that change.
- Communication is key. Keep us informed and involved with what is happening. Not knowing what is going on is very frustrating and is not good for our health! So talk to us; the only people who really know how our healthcare system works are the patients. We are also the only people who get to see the whole system in operation from beginning to end. You only see one small part of it in your day job unless you're also lucky enough to be an NHS patient!

Gratefully yours,

The patient and public reference group

Executive summary

Context

In February 2014, Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups (CCGs) agreed to work in partnership with providers and neighbouring commissioners to establish a programme called *Transforming Services, Changing Lives*. This programme aims to assess east London's health economy regarding hospital care and how specialties work with primary and community care services.

To tackle the challenges we all face, we are planning for changes that will improve the health of the local community and prevent ill health. We are now taking forward this work as part of a programme called *Transforming Services Together*. This is about how we transform the whole health care system in east London.

The case for change is clear

- Our population is growing and the local NHS needs to respond to increased demand, for example in maternity and children's services
- We need to better care for the increasing number of people with long-term conditions
- We and our partners need to work together more closely to strengthen our prevention approaches, supporting people to live healthier lives and improving physical and mental wellbeing
- The local NHS needs to invest time and effort in tackling inefficiencies. Estates, IT systems and care pathways sometimes do not work for the greatest benefit of patients or staff
- We need to fix our urgent-care system, ensuring patients are seen in the right care setting for their needs
- We need a transformed workforce for 21st-century care – with different skills and roles, working in different settings
- Changes will need to be made to local services if they are to be safe and sustainable. More services need to be provided in the community, closer to people's homes
- The local NHS and partners will need to work together to secure high-quality and financially sustainable services in east London.

In July 2014 we issued an interim *Case for Change*. It described local NHS services and celebrated the excellent services we are delivering. But it also identified where we need to improve services and ensure we deliver better value for taxpayers' money. The process of establishing our *Case for Change* brought together healthcare professionals from a range of organisations and patient representatives, to share their expertise and knowledge and create a community for change – people committed to improving care and ensuring the sustainability of local NHS services.

Over the summer, we set ourselves the goal of testing our ideas with about 1,500 people rather than the 150 who helped develop the interim document. Since July, we have engaged with almost 3,000 people, ensuring that the initial sense of excitement and opportunity has spread further than we had hoped possible.

The engagement

We tested our ideas and sought views in a number of ways. We analysed feedback from over 90 meetings and events; 64 questionnaires; focus groups (maternity and newborn; young people; and long-term conditions); and from interviews with people in outpatient departments (children and young people).

The programme and its aims were generally welcomed wherever we went and whoever we talked to. The process was well received and, as expected when discussing the NHS's future, there was healthy debate and challenge. A number of contributors felt it was helpful to get people together, sitting round a table and discussing the important issues. The documents were described as clear and honest. We heard...

- Almost everyone felt the NHS needs to change in some way
- Patients should be the focus of the NHS and its partners above all else, with equal dedication to best patient experience and improved outcomes
- We need to focus on improving the population's health and wellbeing
- The NHS needs to modernise. This will drive better patient care.

This 'word cloud' summarises the main comments made at the meetings we held



The Case for Change

Our original proposal was that four key factors underpinned the need to change:

- **Health and wellbeing:** given the public health problems of most western societies and local factors in east London
- **World-class services:** we need to develop these as there is a lot of variation at present
- **Our workforce:** is currently under pressure and needs to change to tackle modern health problems
- **Resources:** are sometimes being used inefficiently and unproductively.

Our engagement provided considerable support for these factors which expanded our understanding of why services need to improve. The diagram on page 29 shows a slightly amended representation of the key elements of the case for change. For instance:

- Patients are now firmly in the centre of the diagram. Patients encouraged us to see everything from their perspective, as well as viewing patient experience as critical to NHS services
- The workforce is represented next to the patient – indicating the role staff have as the first point of contact and through whom all the other factors are viewed and experienced. The workforce can exacerbate problems in other factors or remove or reduce problems
- Accessible care has been added. This recognises that for too many people transport is not the limiting factor: a lack of information; inconvenient opening times; long waiting times; complex referral processes; some services not being available are often much more relevant for patients.

Our community

East London, one of the most exciting communities in the world, suffers from challenges similar to those in many parts of the country – particularly unhealthy lifestyles and an ageing population. These lead to increasing numbers of people with long-term conditions, such as diabetes. There are also local difficulties: high deprivation, rising birth rates and a growing population. We expect another 270,000 people to be living here in the next 20 years, equivalent to a whole new borough. These factors, as well as the rapid movement of population and our ethnic mix, mean we need to go further than elsewhere in the country in our work to innovate and improve services. We also need to be aware of innovations and improvements in neighbouring boroughs, which may affect patient flows, for example the changes to King George's Hospital in Ilford and agreed specialist cancer and cardiac changes across north central and north east London.

There are good examples of innovative prevention and disease management. But the NHS, working with local councils and other partners, needs to focus better on preventing ill health, recognising that improved wellbeing can stop, reduce the effect of, or delay the onset of diseases. Health and wellbeing boards are strongly committed to the need for change.

Everyone is responsible for good health but at the moment people are not encouraged enough to keep healthy. When they do fall ill, the current system does not consistently support people to manage their own health and make informed choices.

World-class services

We have examples of excellent clinical care, but most services are of variable quality. In primary care, the community and our hospitals the quality of care depends on where you live, what service you need and what time of day you need it.

More treatments, and more expensive treatments, will mean we need to make choices. The more efficient we can become, the better and more comprehensive our services will be. Most importantly, poor efficiency can lead to poor patient experience. This can cause irritation (for instance, delays in outpatients), but it can also cause poorer health outcomes for patients (e.g. operations being cancelled). Patients were very clear that their experience of care is just as important as the clinical care they receive and should not be seen differently. Inefficiencies also mean we waste resources (e.g. through re-booking expensive theatre time or repeating tests because staff cannot access or have mislaid results). This can harm patients and damage the NHS's reputation.

World-class services are no use if people cannot access them. However, travelling to services was not a significant issue in the feedback we heard. Patients were much more concerned about the NHS's inability to direct them to the right person or service; delays in seeing the right person; and different services available (or unavailable) in different locations (the 'postcode lottery').

Sustainable support

To make the current system of health and social care sustainable, we need better joint working between all organisations involved in health and social care to prevent ill-health, integrate care and use scarce resources wisely – for example, by commissioning or supporting local community and health groups to provide support.

We have some of the most modern facilities in the country, but we also have old facilities that do not contribute to a good patient experience or clinical care, and are costly to run. We need to modernise our estate, our technology and our ways of working to enable better care and make savings. The public identified many areas in which the NHS seems to accept poor practice. Staff voiced their frustration at being unable to change 'the system'.

Our workforce

It is hard to recruit and keep the skilled workforce we need. In future, we will need a very different workforce. An example is the role that clinical navigators are already starting to play in helping patients get joined-up care across providers. Extended roles for specialist nurses and physicians' assistants are also two new and emerging areas. Medical students just starting their training, depending on their profession, will take between five and ten years to become qualified – so we need to tackle current difficulties and develop a workforce that has the skills to provide a different type of service, working across the organisational boundaries that now exist.

Next steps

Newham, Tower Hamlets and Waltham Forest CCGs have produced a *Five-year Strategy* that sets out how organisations will work in partnership to:

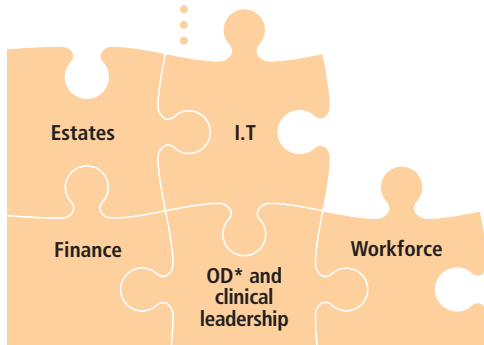
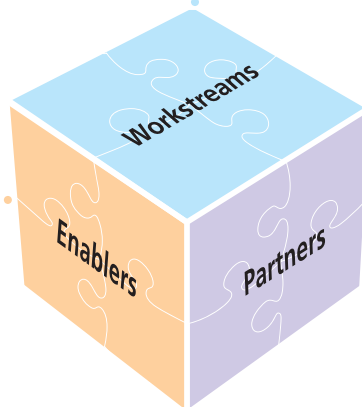
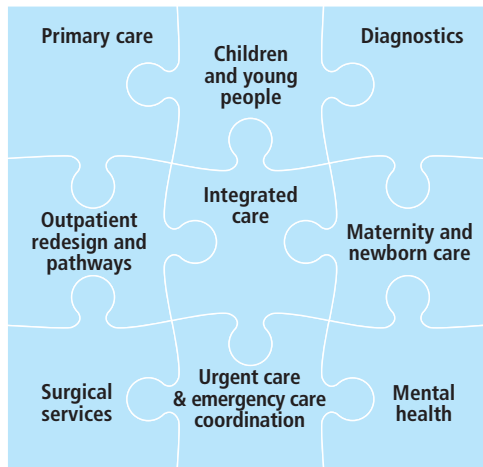
- help patients to be in control of their own health so they lead longer and healthier lives
- provide more co-ordinated health, social and mental health care in our communities
- improve hospital services and primary care services, including GPs
- ensure our budget is spent wisely, to provide a more sustainable health service.

The findings of *Transforming Services, Changing Lives* will form the basis of work to improve hospital-based service through a new programme designed to look at the whole health and social care economy described in the *Five-year Strategy*. *Transforming Services Together* will have nine care-delivery workstreams.

The next stage of our work is to understand more precisely where and how services and care models need to change for each patient group. This will develop into more detailed proposals that we can fully evaluate to understand how these and existing plans help tackle financial problems. We will continue to talk with key stakeholders, the public and patients to build our strategies within *Transforming Services Together*.

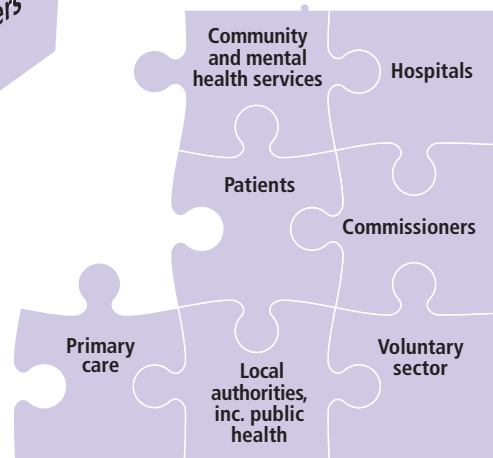
Transforming Services Together programme

Workstreams



*Organisational development

Enablers



Partners

1 About *Transforming Services, Changing Lives*

Transforming Services, Changing Lives aims to jointly develop plans to meet health and healthcare challenges and opportunities in east London.

Programme aims

- To improve services and health outcomes
- To enable clinicians, commissioners, patients and providers to sustainably and positively plan for change together
- To develop a clinically led case for change and a clinical community for change across east London
- To ensure services meet the needs of our complex population

Our initial focus is on hospital-based services, but we have looked across the whole health and social care system to identify where change is needed, including within local authorities and public health.

Organisations involved

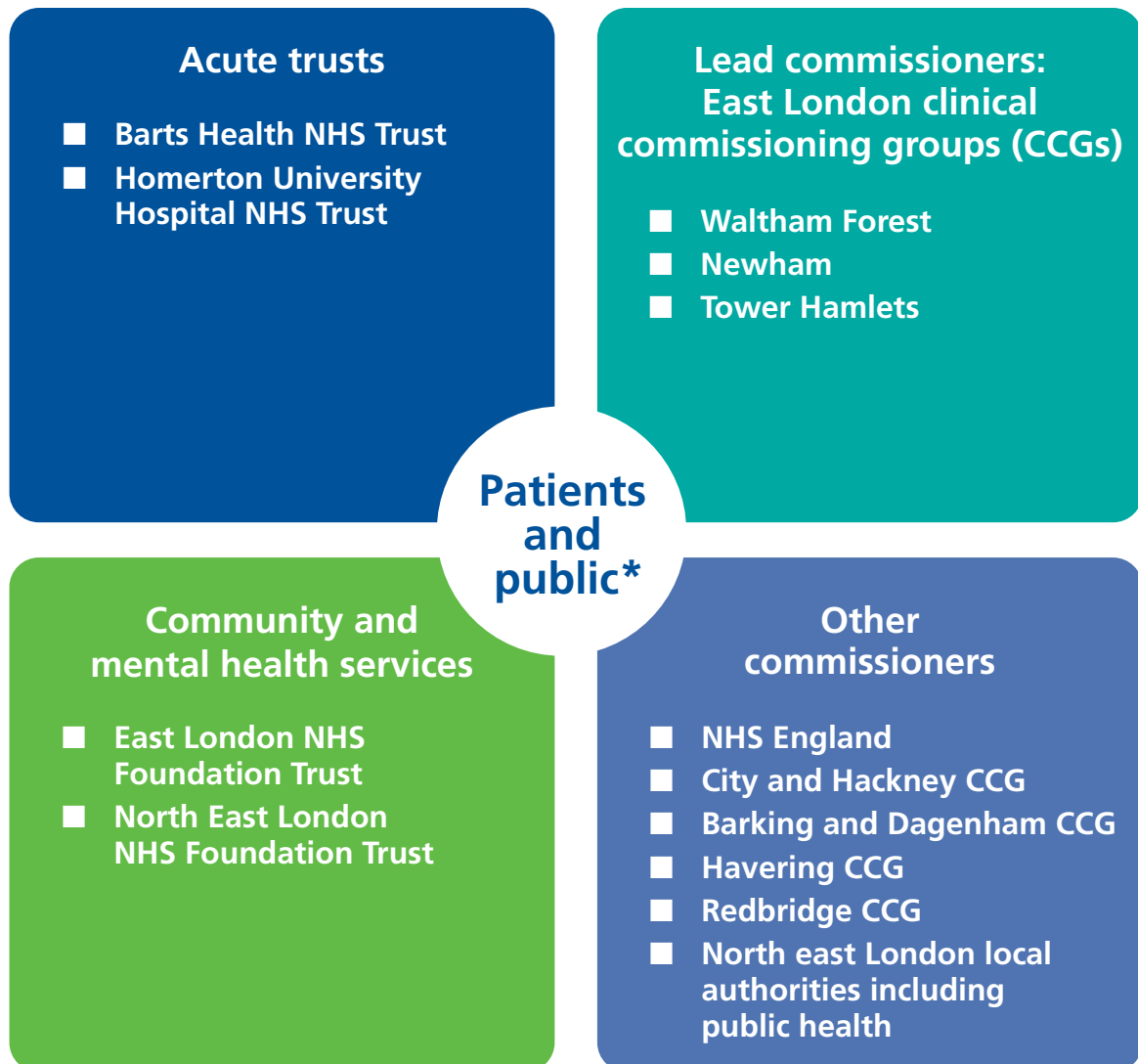
In February 2014, Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups agreed to work in partnership to establish *Transforming Services, Changing Lives*. We asked local providers, commissioners and patient representatives to take part.

The organisations shown on the next page joined the programme, providing expertise and representation on committees and clinical working groups. Local organisations such as City and Hackney Clinical Commissioning Group were also important consultees. Most discussions have focused on Barts Health NHS Trust (Barts Health) services, but both Barts Health and Homerton University Hospital NHS Foundation Trust (Homerton Hospital) took an active part in discussions.

Our engagement (see section 4) focused on Newham, Tower Hamlets and Waltham Forest but included organisations, patients and members of the public from neighbouring boroughs. This is because people from these communities use our services and could be affected by service change.

"I am impressed with the engagement process and development of the Case for Change"
PPRG member

Organisations involved



*Patient and public reference group (PPRG): consisting of patient representatives from Healthwatch, acute trusts, community and mental health services and CCGs

Where east London residents go for treatment⁶

CCGs	Newham	Whipps Cross	Barts and Royal London	Total Barts Health Trust	Homerton Foundation Trust	BHR* Hospitals Trust	Other**	Total
North east London - A&E attendances								
Tower Hamlets	900	300	62,500	63,700	2,000	600	16,000	82,300
Newham	49,000	4,500	9,500	63,000	1,500	3,500	28,000	96,000
Waltham Forest	1,000	43,500	2,500	47,000	3,500	1,000	14,500	66,000
City & Hackney	300	600	7,500	8,400	62,000	400	23,000	93,800
Barking & Dagenham	2,500	600	1,500	4,600	400	42,000	19,000	66,000
Redbridge	1,000	14,000	2,500	17,500	700	38,000	14,000	70,200
Total	54,700	63,500	86,000	204,200	70,100	85,500	114,500	474,300
North east London - unplanned admissions								
Tower Hamlets	200	100	13,500	13,800	300	100	1,500	15,700
Newham	15,000	1,500	3,500	20,000	200	600	1,500	22,300
Waltham Forest	300	17,000	1,500	18,800	400	300	1,500	21,000
City & Hackney	100	200	3,000	3,300	10,000	100	2,000	15,400
Barking & Dagenham	800	200	900	1,900	100	10,000	700	12,700
Redbridge	300	5,000	1,500	6,800	100	10,000	1,000	17,900
Total	16,700	24,000	23,900	64,600	11,100	21,100	8,200	105,000
North east London - planned surgical admissions								
Tower Hamlets	100	0	7,000	7,100	400	0	2,500	10,000
Newham	6,500	2,000	2,500	11,000	500	300	2,500	14,300
Waltham Forest	100	10,000	1,000	11,100	500	100	3,000	14,700
City & Hackney	0	100	1,500	1,600	7,000	0	4,000	12,600
Barking & Dagenham	200	300	500	1,000	100	7,000	3,000	11,100
Redbridge	100	4,500	900	5,500	200	6,000	5,000	16,700
Total	7,000	16,900	13,400	37,300	8,700	13,400	20,000	79,400

* Barking, Havering and Redbridge Hospitals NHS Trust

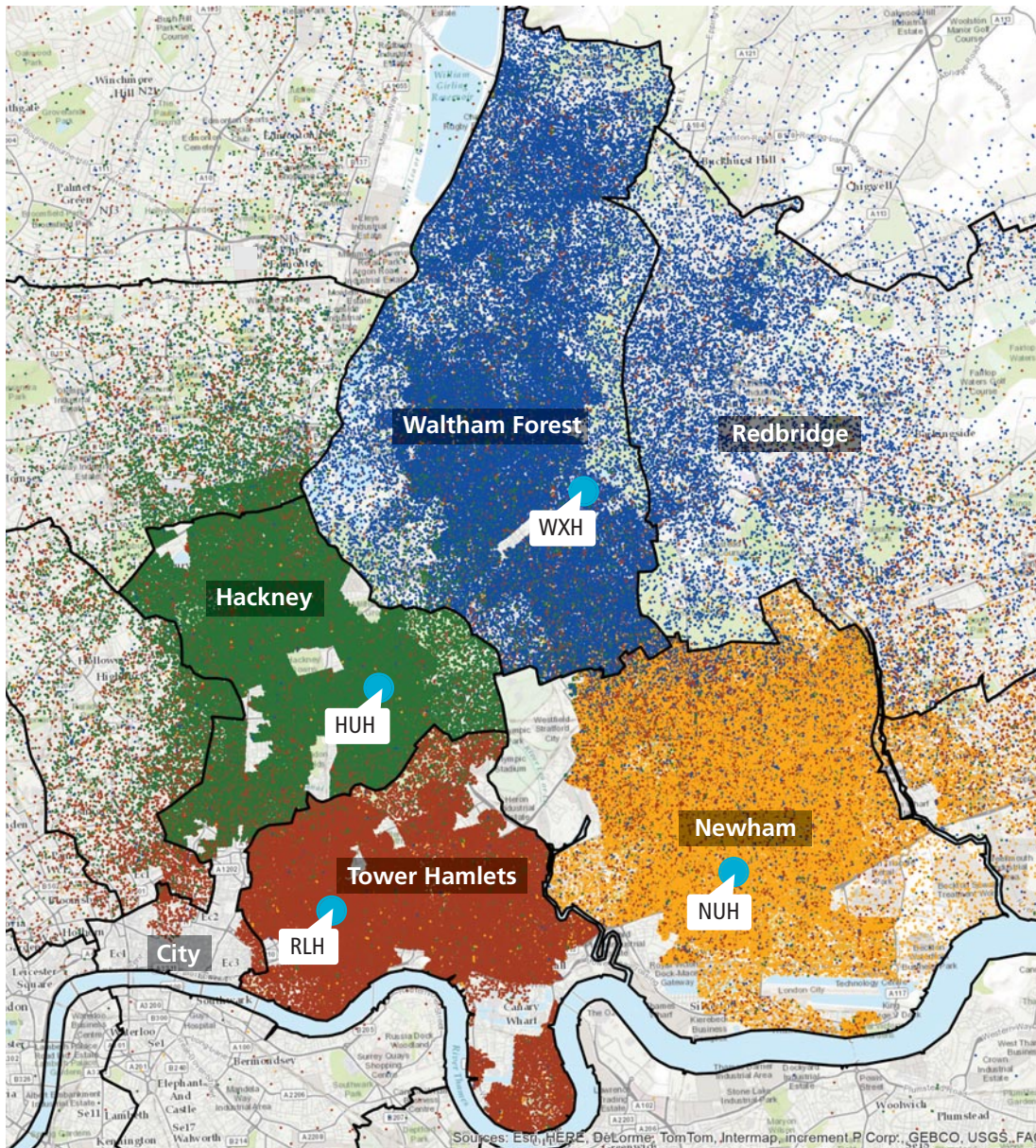
**For A&E attendances, this includes attendances to A&Es outside north east London (e.g. University College London Hospitals, North Middlesex Hospital and Moorfields Eye Hospital) and attendances to urgent care centres in north east London but run by trusts other than those listed in the table (e.g. Newham Urgent Care Centre, which is run by East London NHS Foundation Trust.)

"I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me"

National Voices

⁶ Source: Secondary Uses SUS submissions, period 01/10/2012 – 30/09/2013. All figures individually rounded – numbers < 1,000 to nearest 100, numbers > 1000 to nearest 500. The 'total' north east London figures include the London Borough of Havering.

A&E attendance for adults and children



1 dot = 1 visit ● Hospital

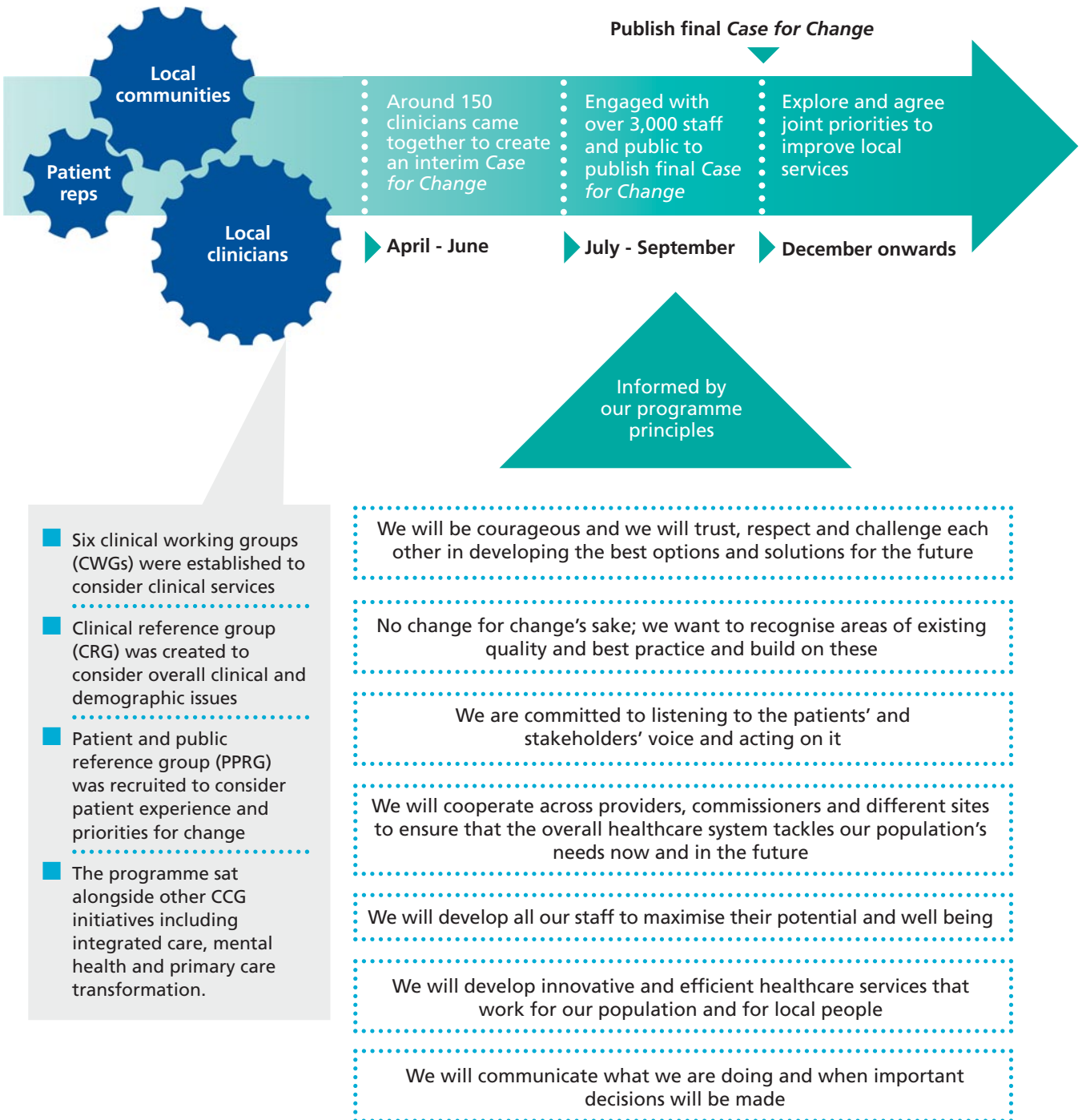
● Attendees at Homerton University Hospital (HUH)

● Attendees at The Royal London Hospital (RLH)

● Attendees at Whipps Cross University Hospital (WXH)

● Attendees at Newham University Hospital (NUH)

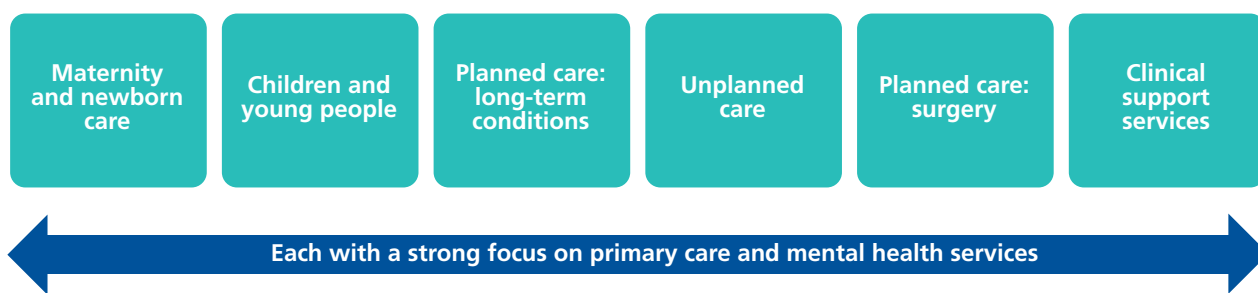
We are on a journey to improve services for the whole community



Six clinical working groups (CWGs)

Clinical working groups brought together clinicians from across primary, community and hospital services to:

- describe the current state of services
- identify if change is needed to improve services for patients
- begin to develop a shared vision for how the local NHS can improve



Interim clinical working group reports were developed by each clinical working group in July 2014 and further tested with clinicians, patients and the public throughout the summer. These finalised reports form appendices to this document and can be found on our website www.transformingservices.org.uk

The patient and public reference group (PPRG)

Public and patient representatives were invited from the organisations below to help develop the *Case for Change*, guide the engagement process and provide ideas and challenge to clinicians leading the programme. Members were nominated from:

- **Healthwatch:** Waltham Forest, Tower Hamlets, Newham, Redbridge, Barking and Dagenham, Hackney, City of London and Essex
- **Clinical commissioning groups:** Waltham Forest, Tower Hamlets, Newham, Redbridge, Barking and Dagenham and Hackney
- **Hospitals:** Whipps Cross University Hospital (Whipps Cross Hospital), Newham University Hospital (Newham Hospital), The Royal London Hospital, Mile End Hospital, The London Chest Hospital and Homerton Hospital
- **Mental health and community providers:** North East London NHS Foundation Trust and East London NHS Foundation Trust.

Clinical working groups have considered the following national policy context in their discussions:

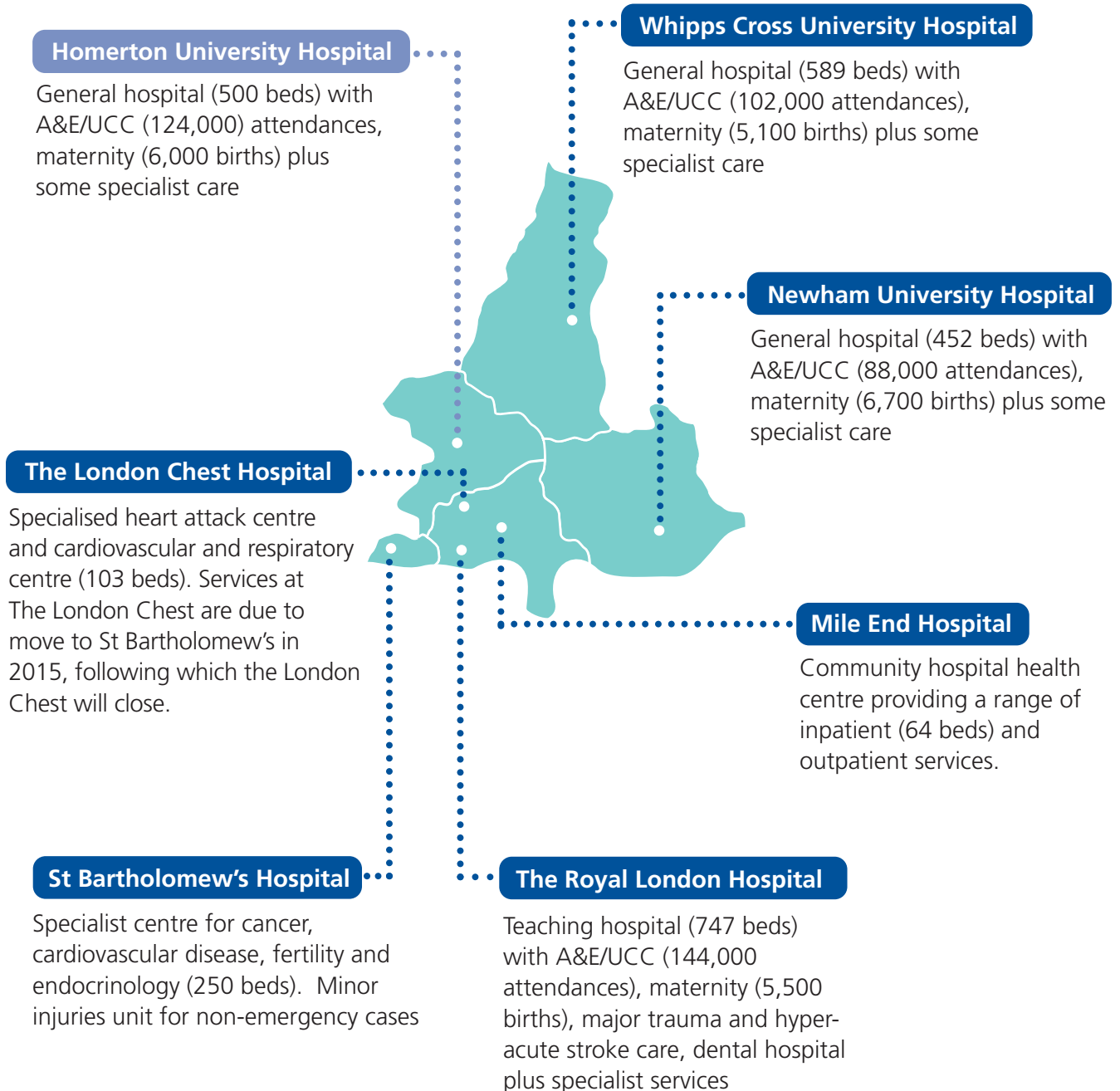
Many of these policies aim to create a higher-quality and more efficient health and social care system. But there are also some challenges, for example reduced social care funding.

For the NHS...		
Involving citizens in services design	Patients fully empowered in their own care	Primary care, provided by working together
Modern, integrated care	Access to the highest-quality urgent and emergency care, in line with emerging recommendations from the Keogh review	A major change in the productivity of planned care
Specialised services, concentrated in centres of excellence	A focus on quality and the governance of quality	Seven day services
	Royal college and network recommendations for clinical services e.g. neonatal care	

For mental health services...	For community health services...	For social care services...
Ensuring mental health and physical health are recognised as inter-related and equally important	Community services need to be more closely connected to all other parts of the health and social care system	The funding of social care is a significant issue. Over the past few years, fewer people have been receiving funding for care
All public services must reflect the importance of mental health in their planning	Close alignment with the rest of the healthcare system will enable community services to be a driving force in improving the health of individuals and communities	The new Care Bill will raise the upper threshold for means testing and introduce a cap for private spending on social care – so people who would otherwise have had to pay for care may qualify for social care support
Enable better access to mental health services with short waiting times	Community health services need to be much more closely involved in key decisions about patients at an earlier stage in their path through the system	However, at the same time, to qualify for services, people will need to show a more significant need
Improve access to psychological therapies		The effect on NHS services of more people receiving social care in their own home or a care home will need to be monitored, particularly in light of changes to allocations resulting from the <i>Better Care Fund</i>
Designing a new measure for wellbeing		

2 The east London and the City health economy

Hospitals

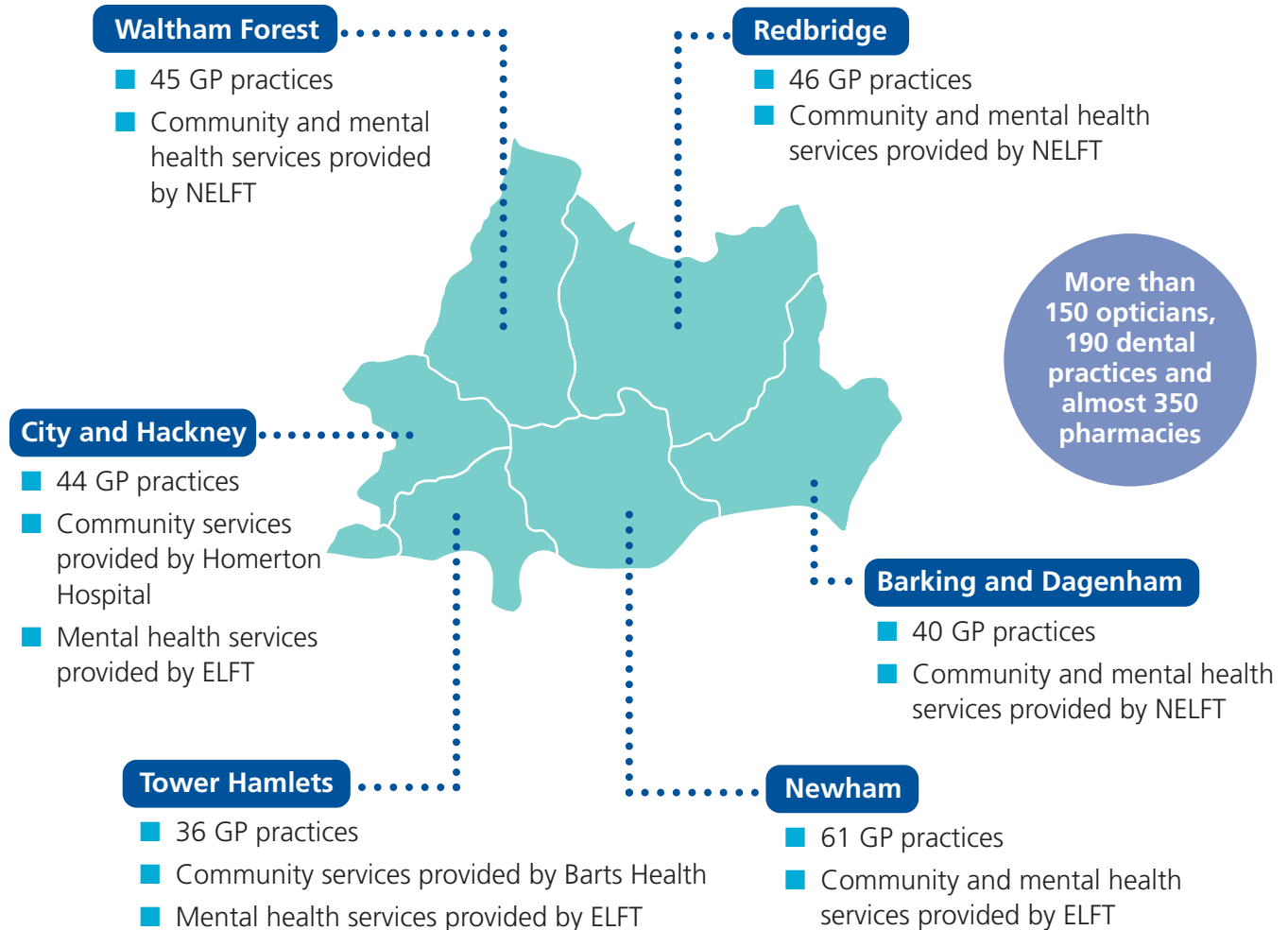


- Barts Health NHS Trust
- Homerton University Hospital NHS Foundation Trust

Primary, community and mental health services

The number of GP practices per borough ranges from 36 in Tower Hamlets to 61 in Newham, suggesting different types of primary care are operating, with varied numbers of practices with one GP (6-29%). There are also different types of mental health and community service provision, for example:

- acute trusts provide some community services in Tower Hamlets and City and Hackney
- community trusts provide mental health and community services in the other four CCGs



NELFT – North East London NHS Foundation Trust
ELFT – East London NHS Foundation Trust

3 Our vision

We want an NHS that gives high-quality care in a financially sustainable way. We also want an NHS that improves health and wellbeing, works with partners to prevent ill health and ensures that the right care is provided, at the right time, in the right place:

1



Improves health and prevents need for health services

The NHS working with an active local authority and voluntary sector to improve health, reduce health inequalities and prevent the need for health services



People are supported to manage their own health, self-care and use their NHS services appropriately – back up by high-quality and responsive primary care services

2



When need arises, ensures right care, right time, right place

Specialised services



Enhanced primary and community care services

Local hospital services

Rare / dangerous / complex needs best treated by a specialist

Acute episodes of care treated efficiently according to severity / urgency

Actively managing long-term conditions with patients to reduce hospital admissions

We want our population to have good health and experience good care

Our *Case for Change* tells us that patients expect:

■ Consistently high-quality and efficient services

■ Good patient experience and information:

- Individual services for patients, taking account of their own circumstances
- Continuity of care – so patients do not have to constantly repeat their case history or undergo repeat tests
- Short waiting times for appointments
- Text reminders about appointments and the ability to book online
- Access to the right advice, test results and service, in the right place, first time
- Being seen on time, given advice and kept updated
- Friendly, welcoming and trustworthy staff

■ Support with managing their own health:

- Non-judgemental advice on living more healthily and making good choices
- Promotion of good mental health and wellbeing, including access to suitable services when needed
- Enough information and time to ask questions at a consultation

Staff have told us this can be achieved by...

■ Consistently high-quality and efficient services

- Good transitions between and within organisations, with clear clinical responsibility in handing over care
- Maximising the use of new technology to improve outcomes within services

■ Good patient experience and information

- Effective IT systems that can communicate care records across organisations
- Investing in a happy, engaged, flexible and well-trained workforce

■ Support with managing their own health

- All parts of the system working together and supporting good health: social care, schools, primary care, community care, mental health services, hospitals and public health departments
- Clear information about available local services and the development of consistent pathways of care
- Training and development in promoting change in patients' behaviour

4 Summary of engagement: developing this document

In our engagement work, we aimed to inform people, test ideas, invite comment and, ultimately, start building a community for change.

We aimed to increase the number of people engaged with the programme from about 150 who took part in developing the interim *Case for Change* to 1,500. We published the interim *Case for Change* on 9 July 2014 and asked to hear from anyone with an interest in the health of local residents and the healthcare economy over the summer months. Our engagement period ended on 21 September 2014.

We are very grateful to over 350 east London, the City and Redridge clinicians and almost 3,000 patients, members of the public or members of stakeholder organisations who have given their time to develop and contribute to this document.

The programme and its aims were generally welcomed wherever we went and whoever we were talking to. The process was well received and, as would be expected when discussing the NHS's future, there was healthy debate and challenge. Everyone who responded to the questionnaire wanted the NHS to change in some way. Those who took part in our engagement said the programme was a good way of getting people together, sitting round a table and discussing the important issues. Our interim *Case for Change* and accompanying documents were described as being clear and honest.

Engagement resources

The resources we used were tested with our patient and public reference group, programme executive and communications steering group.

The resources consisted of:

- publicity, e.g. flyers and media releases informing people of the engagement
- documents, e.g. summary and full version of the *Case for Change* and PowerPoint presentations
- a questionnaire on healthcare in east London, available in hard copy and online
- a website that provided a repository for the significant number of documents produced.

"I like that [the Case for Change] is a very honest report"
Waltham Forest female resident and NHS staff member, aged 16-25

Engagement activity

- We attended 90 stakeholder meetings and ran a number of events specific to the *Case for Change*, e.g. information stands at hospitals and an event in partnership with Waltham Forest, Newham and Redbridge Healthwatch, at Whipps Cross Hospital
- 64 people expressed their views via the questionnaire (both online and on paper).

Additionally, we organised a number of focus groups and interviews with patients and the public, particularly in areas where clinical working groups felt the public and patient voice was not strong enough:

- We held two focus groups – one for young mothers and one for those with long-term conditions
- We interviewed young people and met young advisers in Waltham Forest (as the patient and public reference group had no young representatives).

We also did further clinical engagement over the summer to develop the ideas of the clinical working groups with more clinicians, particularly across Barts Health.

The responses

The need for change was almost universally agreed and the path we were taking was broadly welcomed, with support for the overall vision. Responses also supported the way we had described local difficulties and areas of work that need to change.

A major theme was poor administration and poor patient experience. When patients see a clinician they are generally satisfied. But poor administration and patient experience (which includes waiting times, being able to access care, being well informed, being treated with respect and the quality of the environment), and inefficient and confusing patient pathways were highlighted as problems.

Patients and the public praised plenty of clinical practices and procedures. But they voiced strong frustration over late appointments, appointments where tests or scans were unavailable, being passed from one specialist to another, and a feeling of not being in charge of their own care.

The staff who responded recognised all the points made by patients and the public. Staff felt frustrated at poor internal communications, which left them unaware of the different support options available for patients or the involvement of other NHS staff. They said poor IT systems and fragmented patient pathways (the routes patients take through their treatment) make the job more difficult than it needs to be. And they said variations in commissioning create unnecessary differences in the care people get. In summary, staff feel there are inefficiencies in the NHS that make it hard for them to do their jobs.

There was no clear difference of opinion on these matters among patients and the public, different age groups, ethnicities, genders or people with disabilities. The themes were recognised by people regardless of where they lived, but some geographical differences were noted. For instance:

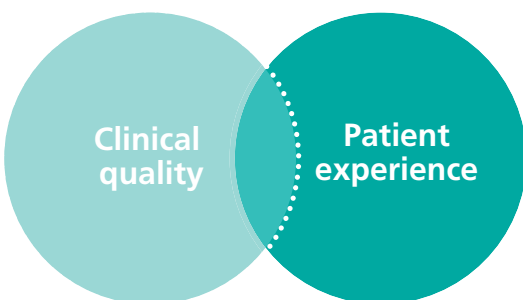
- People in Waltham Forest were concerned about the future of Whipps Cross Hospital, the quality of the estate and the cost of running The Royal London Hospital
- People in Newham were concerned about the future of Newham Hospital
- People in Tower Hamlets were concerned about the administrative systems at The Royal London Hospital.

1 Patient experience and 'customer' satisfaction

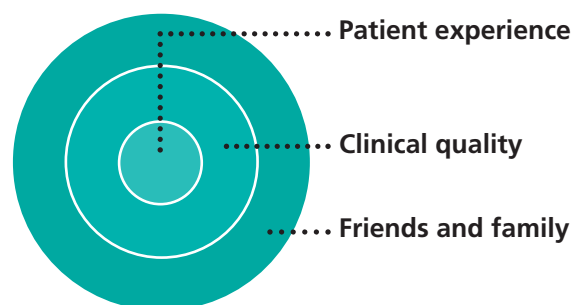
Patients said their experience of care is just as important as the clinical care they receive.

Patients said clinical quality and patient experience should not be seen as different and encouraged the NHS to always see everything from a patient's perspective (see diagram below).

The NHS view



The patient view



2 Health and wellbeing

Patients and the public accepted that people needed to take more responsibility for their own health if the population was to become healthier. However, there was a general view that people needed support to make changes to their own lives, and that the NHS is not currently set up to provide it. Far better information and support methods are needed if patients and the public are going to manage their own health better.

3 Efficiency and productivity

There was some call for greater funding of the NHS, but most people seemed to accept that the NHS can reduce waste to improve efficiency and productivity. Staff and patients identified numerous instances where inefficient processes were adding to the financial burden; and a great many opportunities for introducing smarter working. These findings echo the work of the Academy of Medical Royal Colleges (2014) which suggested there is an ethical duty to prevent waste within the health service and pointed to potential NHS-wide savings of up to £2 billion per year⁷.

Conclusion

Part of the purpose of consultation is to:

“allow those consulted to give intelligent consideration and an intelligent response... One of the functions of a consultation process is to winnow out errors in the decision-maker’s provisional thinking. True consultation is...not a matter of how many people object to proposals but how soundly based their objections are”⁸

This was an engagement process but our aims were almost the same as those of a consultation. Our engagement has allowed intelligent consideration and response. It has enabled us to understand errors in our first thoughts. And we can take heart from the clear consensus that there is a strong case for change and agreement about what change is needed.

We shared the results of our engagement with each of the clinical working group’s programme executives and have used their comments to improve this *Case for Change*.

“There is a real opportunity here... if these things can be worked through early and are done well, to really improve things”
Barking and Dagenham Health and Wellbeing Board

⁷ Association of Medical Royal Colleges (2014): *Protecting resources, promoting value: a doctor’s guide to cutting waste in clinical care*
⁸ R (Brompton and Harefield NHS Foundation Trust) v Joint Committee Of Primary Care Trusts & Anr – Court of Appeal (19 April 2012)

5 The Case for Change: key factors

The *Case for Change* is based around patients. Key factors driving the need to change have been grouped:

- Our community
- World-class services
- Sustainable support
- Our workforce

There are dependencies between different factors and groups of factors. There will also be other factors that influence the case for change, for instance the political environment. However clinicians, stakeholders, patients and the public recognised these groupings – set out below. The following sections look at each group of factors in turn.



6 Our community

Our population's health can be improved. There are too many early deaths from preventable diseases, and life expectancy is short compared to the rest of England. There are wide health inequalities across our area.

The main local factors contributing to the poor health of the local community include high deprivation, rapid movement of population and a rich ethnic mix. To tackle these needs, we have to innovate and improve our services more than elsewhere in the country.

The population is growing and changing rapidly

The population is growing faster than anywhere else in the country. The highest proportionate change is among the over 65s. This means demand for health services is going to increase over the next few years and, to respond well, they will need to change.

Services need to be designed to meet the population's particular needs

In east London we have some innovative prevention and disease management services but we need to do more if we are to keep people healthy and support them to manage their conditions. We need to change services in a way that responds to the population's particular needs and reduces health inequalities.

Improving health requires us to work together

Everyone has a responsibility for good health: the NHS and other health services, local councils, health and wellbeing boards, businesses, schools, patients and the public.



6.1 The health profile of the three boroughs

This section gives an overview of the health issues in east London (Tower Hamlets, Newham and Waltham Forest). For a fuller description, please read the Joint Strategic Needs Assessment (JSNA) reports published annually by the Public Health Director of each borough⁹.

The three boroughs have a diverse population and extremes are recorded in every social and health indicator. The Greater London Authority estimates that the population of the three boroughs is 861,000 people, of whom 174,000 are children and 64,000 are elderly.

⁹ Tower Hamlets JSNA: http://www.towerhamlets.gov.uk/IGSL/701-750/732_jsna.aspx, Newham JSNA: <http://www.newham.info/jsna>, Waltham Forest JSNA: <http://www.walthamforest.gov.uk/Documents/JSNA-Report-2014.pdf>

2013 GLA population estimates

	Tower Hamlets	Waltham Forest	Newham	Total
Age 0 to 14	50,597	55,035	69,199	174,831
Age 15 to 64	204,617	184,138	233,829	622,584
Age 65 and over	15,911	26,966	21,666	64,543
Total	271,125	266,139	324,694	861,958

This is a young population compared with the rest of London and England. As a proportion of the total, there are more children and fewer older people than elsewhere.

The health of our population could be improved

The table below shows that life expectancy is worse in Newham and Tower Hamlets than in the rest of England. Healthy life expectancy is the number of years from birth that a person can expect to remain in 'good' or 'very good' health. As for life expectancy, the healthy life expectancy for the residents of the three boroughs is shorter than for the population of England.

Life expectancy and healthy life expectancy at birth

	Note	Newham	Tower Hamlets	Waltham Forest	England		
					Worst	Average	Best
Life expectancy (male)	1	77.5	76.7	79.0	73.8	78.9	83
Life expectancy (female)	1	82.0	81.9	83.1	79.3	82.9	86.4
Healthy life expectancy (male)	2	58.8	52.5	62.7	52.5	63.2	70
Healthy life expectancy (female)	2	56.4	57.2	57.9	55.5	63.6	71

Significantly worse than the England average

1. Years of life at birth 2012

2. Estimated years spent from birth in 'good' or 'very good' health 2010-2012

Not significantly different from the England average

Significantly better than the England average

The local population is relatively young so there is a low prevalence of diseases associated with old age such as cancer, respiratory conditions, cardiovascular and heart disease. However, the table on the next page shows that in Tower Hamlets and Newham more people than should be expected are dying early from these and other diseases. So there are fewer people with life-threatening illnesses, but those people who are sick tend to have more severe health problems and a poorer prognosis.

Mortality rates for common causes of death

	Note	Newham	Tower Hamlets	Waltham Forest	England		
					Worst	Average	Best
Early deaths – heart disease & stroke	1	87.3	87.0	65.7	113.3	60.9	29.2
Early deaths – cancer	1	102.6	128.5	109.4	153.2	108.1	77.7
COPD – standardised mortality rate	2	138.6	172.1	108.7	197.5	100	39.2

Significantly worse than the England average

Not significantly different from the England average

Significantly better than the England average

1. Directly age standardised rate of deaths per 100,000 population aged under 75, 2009-2011
2. Directly standardised mortality rate per 100,000 population 2010-2012

Selected public health indicators

	Note	Newham	Tower Hamlets	Waltham Forest	England		
					Worst	Average	Best
Hospital stays for alcohol-related harm	1	2,760	2,290	2,637	3,276	1,895	910
Drug misuse	2	11.6	16.3	8.3	26.3	8.6	0.8
People diagnosed with diabetes	3	6.9	6.0	5.9	8.4	5.8	3.4
New cases of tuberculosis	4	137.0	61.0	48.4	137	15.4	0
Acute sexually transmitted diseases	5	1,347	1,926	1,342	3,210	804	162
Perinatal mortality rate	6	8.5	9.7	7.8	11.5	7.2	2.0
Obese children (year 6)	7	25.6	25.1	23.5	28.5	19.2	10.3

Significantly worse than the England average

Not significantly different from the England average

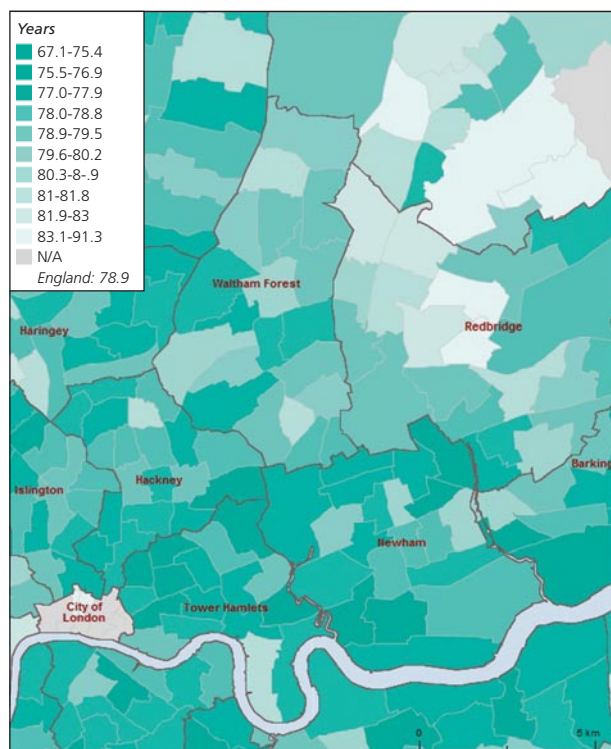
Significantly better than the England average

1. Directly age sex standardised rate per 100,000 population, 2010/2011
2. Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11
3. % people on GP registers with a recorded diagnosis of diabetes 2011/12
4. Crude rate per 100,000 population, 2009-2011
5. Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate)
6. Still births and deaths <7 days per 1,000 births - 2010 to 2012 (pooled)
7. % school children in Year 6 (age 10-11), 2011/12

These indicators show the average rate or percentage for each borough. Within each borough, further analysis has also shown a great deal of variation among the population. The two maps below show life expectancy at birth for smaller areas (super output areas) of east London, with the darkest areas showing the shortest life expectancy. So, even in neighbouring areas in the same borough, people can have very different life expectancy. For example, life expectancy for people living in the docklands area of Newham and Tower Hamlets is up to 13 years more than for people living just two miles to the north.

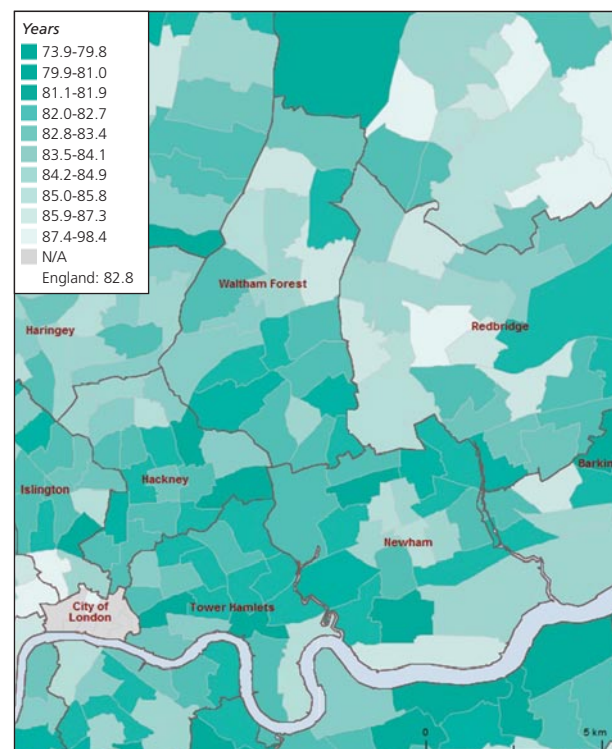
Life expectancy at birth for males, 2008-2012

Source ONS, PHE ©Copyright 2013*



Life expectancy at birth for females, 2008-2012

Source ONS, PHE ©Copyright 2013*



The wide variation across the area in life expectancy is reflected in death rates for various disease type. The maps on the next page show the pattern of early deaths for coronary heart disease and circulatory diseases.

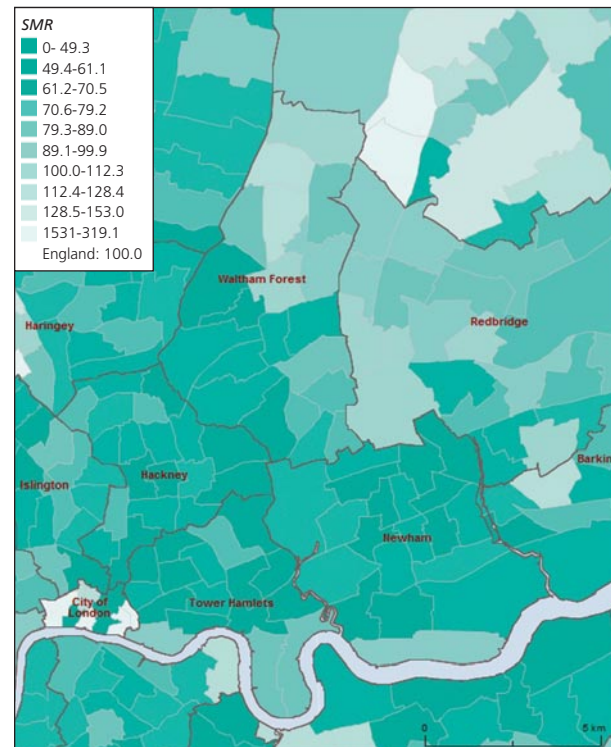
Deaths from coronary heart disease, under 75 years, standardised mortality ratio 2008-2012

Source ONS, PHE ©Copyright 2013*



Deaths from circulatory disease, under 75 years, standardised mortality ratio 2008-2012

Source ONS, PHE ©Copyright 2013*



6.2 Population growth and a changing age profile bring unique difficulties

The population is changing and the local NHS needs to respond. The Greater London Authority predicts that in the next 20 years:

- The population of the three boroughs will grow by almost 270,000 (32%) – the equivalent of a new London borough
- Growth will occur in all age bands and the greatest increases will be among people of working age
- The greatest proportional growth will be among the older age group: over 65s will increase by 37,000 (60%) and form 9% of the population.
- There will be 40,000 extra children in the three boroughs.

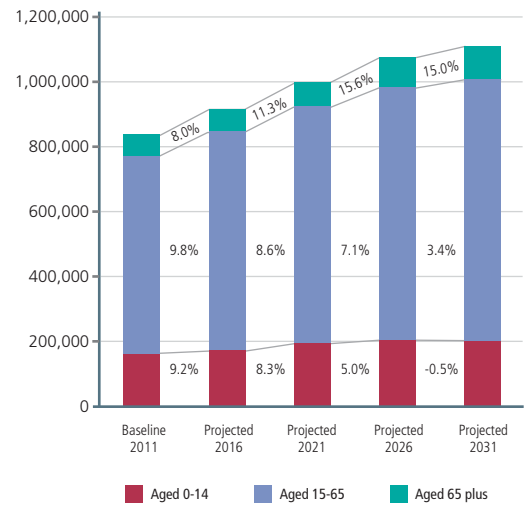
*©PHE - ©Crown copyright and database rights 2014, Ordnance Survey 100016969 – ONS ©Crown copyright 2014 – Ward (2013 boundaries) Upper Tier Local Authority

As children and the over-65s are heavy users of health services, this shift will significantly raise demand for health services above the increase in population.

Neighbouring boroughs will also see high population growth: Redbridge (20%), Barking and Dagenham (34%), City and Hackney (24%).

Population growth 2011-2031: Tower Hamlets, Newham, Waltham Forest combined

(source GLA SLHAA capped model)

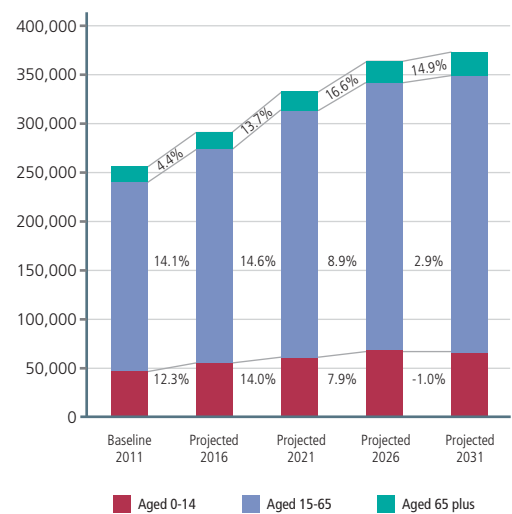


Population growth will mainly be in Tower Hamlets and Newham

Population growth 2011-2031: Tower Hamlets

(source GLA SLHAA capped model)

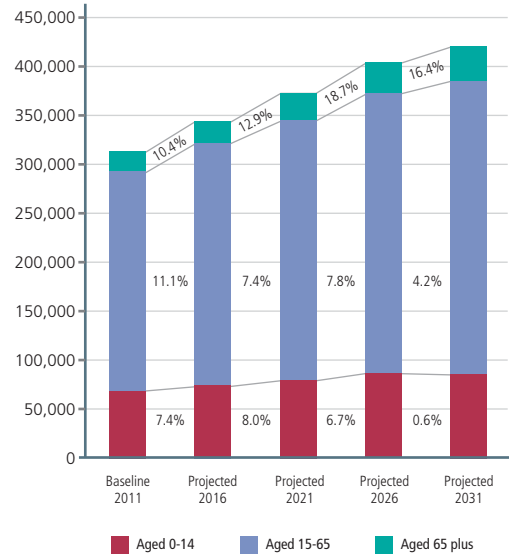
	Projected 2016	Projected 2021	Projected 2026	Projected 2031	Total growth
Baseline 2011	256,694				
Population	290,402	332,233	362,523	373,079	373,079
Growth	33,708	41,831	30,290	10,556	116,385
% Growth	13.1%	14.4%	9.1%	2.9%	45.3%
Annual % growth	2.5%	2.7%	1.8%	0.6%	1.9%



Population growth 2011-2031: Newham

(source GLA SLHAA capped model)

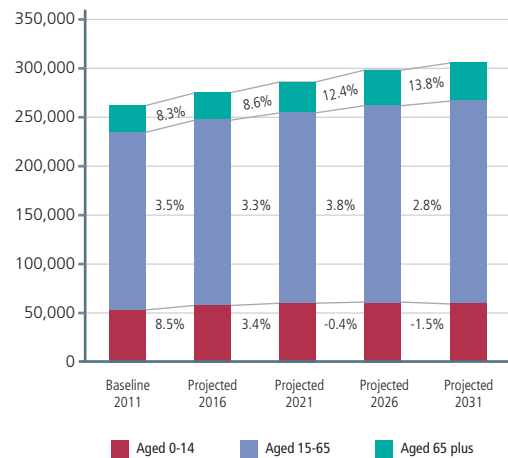
	Projected 2016	Projected 2021	Projected 2026	Projected 2031	Total growth
Baseline 2011	311,917				
Population	343,961	371,224	402,176	419,834	419,834
Growth	32,044	27,263	30,952	17,658	107,917
% Growth	10.3%	7.9%	8.3%	4.4%	34.6%
Annual % growth	2.0%	1.5%	1.6%	0.9%	1.5%



Population growth 2011-2031: Waltham Forest

(source GLA SLHAA capped model)

	Projected 2016	Projected 2021	Projected 2026	Projected 2031	Total growth
Baseline 2011	260,373				
Population	273,453	284,065	295,022	304,514	304,514
Growth	13,080	10,612	10,957	9,492	44,141
% Growth	5.0%	3.9%	3.9%	3.2%	17.0%
Annual % growth	1.0%	0.8%	0.8%	0.6%	0.8%

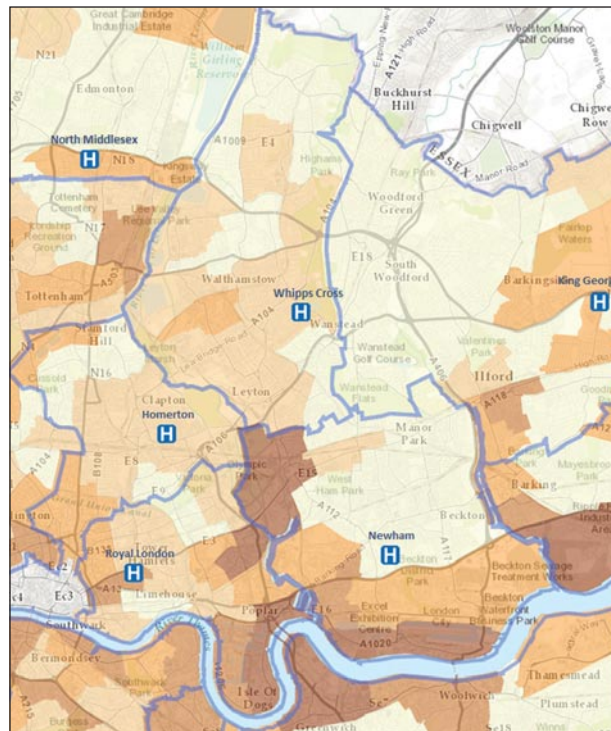


Population growth will be highest in regeneration areas

The map below shows the areas of greatest population growth over the next 20 years.

- Darker-brown areas show electoral wards where growth will be highest. This is in regeneration areas such as the docklands and Queen Elizabeth II Park
- Just eight electoral wards will contribute 100,000 of the 160,000 increase in population forecast for the next ten years
- The main hospital sites surround the areas of high growth and all will be affected.

Map showing areas of highest population growth (source GLA SLHAA capped model)



How population growth affects service planning

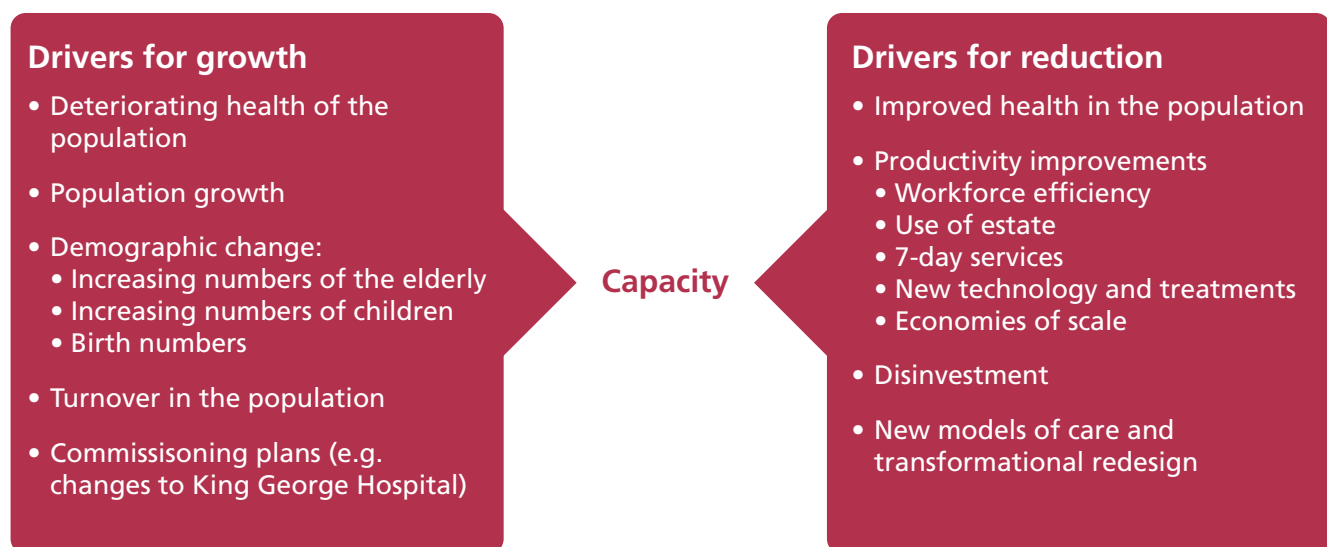
Population growth will create higher demand for health services, meaning we will need higher capacity. More of the following resources will be needed:

- Workforce: doctors, nurses, midwives etc.
- Hospital infrastructure: beds, operating theatres, diagnostics etc.
- Community and primary care infrastructure: clinics, GP surgeries.

When considering our future capacity needs, we take into account factors that will increase demand on local services. Some of these relate to the higher population and the higher number of elderly people. However, we also need to take into account the implications of commissioning decisions in neighbouring parts of London, such as the planned closure of King George Hospital A&E department. This closure will increase patient numbers at Whipps Cross and Newham University hospitals. These factors are described on the left of the diagram below.

We also need to understand how our need for more capacity will be affected by the changes we want to make to work more efficiently and provide new out-of-hospital models of care. These factors are described on the right of the diagram below.

Factors driving capacity planning



Each of these factors affects services in different ways. So, for example, the projected increase in births will need a corresponding increase in midwives, and the increasing population will need a corresponding increase in GPs.

As part of our work, we have considered the number of acute beds we are likely to need in the future. Population growth will increase the demand for hospital beds, but the shift towards giving more care out of hospital and the efficiency improvements we want will reduce the time patients will spend in them. This will free some capacity. So, overall, in the next five years, we estimate that the number of beds in local hospitals will need to stay about the same.

Issues of population and health needs discussed by the clinical working groups (CWG)

Each of the clinical working groups received reports setting out the specific health needs and difficulties in their own area. These are summarised in section 7 of this report. There is more detail in the accompanying clinical working group appendices.

Some of the main issues were as follows:

The Maternity and Newborn CWG identified the rising number of births as a major challenge. The fertility rate (the average number of children born to each woman of child-bearing age) in the area is already high. The population increase will be highest in working-age families so the number of births will continue to rise. In the north east London area, the number of births is expected to increase from 31,500 to 36,400 per year in the next ten years, with most of these births likely to be in maternity units in east London. At the same time the complexity of births is also increasing; there is a high number of babies with low-birth weight and a rising number of pre-term babies.

The Children and Young People CWG heard there are 217,000 children aged 0-19 in the three boroughs, representing 27% of the population. In the next five years this number will grow by 8%, a further 16,000 children. Deprivation is significant in east London, where high child poverty and poor nutrition rates contribute to the demand for health services. The levels of childhood obesity are also above the England average, contributing to a predicted earlier onset of health complications related to long-term conditions. A significant proportion of children have a mental health disorder.

The Long-Term Conditions CWG heard that the prevalence of many long-term conditions such as cardiovascular disease, renal disease and stroke is low compared to other areas of England because the population is younger. One significant exception is diabetes, where prevalence is high and growing. This is likely to reflect the high proportion of the population with a south Asian background. The prevalence of most long-term conditions is low but the death rates are high, showing that people who are sick tend to have more serious health problems such as multiple illnesses.

The Unplanned Care CWG reported on the high use of acute services created by unplanned admissions and attendances at A&E. They heard that the population's diversity and turnover presented special difficulties for providing health and social care.

6.3 Health and wellbeing: factors contributing to the population's relatively poor health

A person's health depends somewhat on 'fixed factors' such as age, gender and ethnicity. But it is now widely accepted that health depends most strongly on social, economic and environmental factors. This is evident from what is known about health inequalities and the reasons for them. The body of knowledge on this issue was fully summarised in *The Marmot Review*, Sir Michael Marmot's strategic review of health inequalities¹⁰.

The central finding of *The Marmot Review* was that differences in people's health are largely explained by differences in their social, economic and environmental circumstances, which affect them from before birth and throughout life. The main factors supporting a healthy life are:

- Access to high-quality care and support for new mothers
- Good parenting
- High-quality early education
- High-quality educational and skills development provision
- A sense of control over one's life
- Secure work
- A workplace that supports health and wellbeing
- An income that is enough for healthy living
- A physical environment that supports health (housing, public space)
- Social and community support networks
- Evidence-based programmes tackling behaviour risk factors for health, such as alcohol misuse
- Access to high-quality health and social care services throughout life.

¹⁰ *The Marmot Review (2010): Fair Society, Healthy Lives*

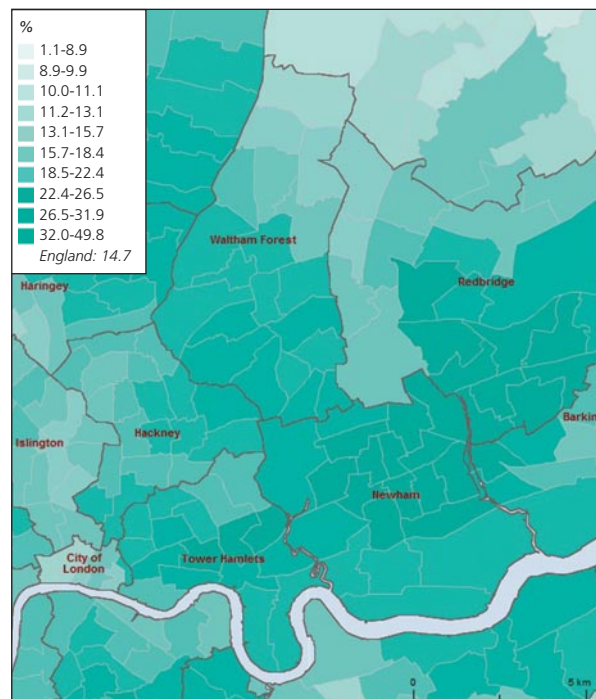
It follows that areas of high deprivation, where there is high unemployment, poor housing, low incomes and low educational attainment, will also have poor health.

Three particular factors contribute to poor health in east London.

- **Deprivation:** the map below shows where households are among the most deprived in England. People living in poverty tend to have poorer health.
- **Ethnicity and language:** Many people in east London do not speak English as a first language (for example, in Tower Hamlets there are 110 languages spoken; around 70% of school pupils have English as their second language; and 55% are from an ethnic group other than white British; but the mix is different in the other boroughs). This adds to the complexity of providing healthcare services to them. Further information on ethnicity can be found on council websites¹¹.
- **Population mobility:** the East End is often the area where new immigrants move to first and then move on, so people and the ethnic mix of the population are constantly changing. This creates an administrative burden and difficulties in providing continuity of care (particularly in general practice). Continuity of care can be a problem with people moving in and out of the area, and health conditions often remain undiagnosed for long periods if people do not understand the NHS and how to access care.

% living in income-deprived households reliant on means-tested benefit. Income domain score from the Indices of Deprivation, 2010

Source CLG ©Copyright 2010



¹¹ Tower Hamlets: www.towerhamlets.gov.uk/lgs/901-950/916_borough_statistics.aspx Newham: <http://www.newham.info/Custom/LEA/Demographics.pdf>
Waltham Forest: <https://www.walthamforest.gov.uk/Pages/Services/statistics-economic-information-and-analysis.aspx>

*©PHE - ©Crown copyright and database rights 2014, Ordnance Survey 100016969 – ONS ©Crown copyright 2014 – Ward (2013 boundaries) Upper Tier Local Authority



These factors go a long way to explaining the variation in the health of the population. So, for example, the low deprivation and low ethnic diversity in the north of Waltham Forest are reflected in longer life expectancy.

Reducing inequality in health service provision

Variation in services may also cause variation in health. This Case for Change highlights both good and bad examples; for example, most medical outpatient services in the area follow a ‘20th-century’ model of care where patients attend rolling check-ups on a routine reappointment system. However, some services, such as diabetes, are gradually introducing appointments through internet services such as Skype that are available when patients most need them.

We believe that the local NHS and partners can do better to ensure that:

- There is equal access to health services
- Services are designed around the local population’s needs
- Services are flexible enough to change as the population changes
- Health inequalities are reduced
- Variations in the quality of services are removed
- In planning any future changes in services, the NHS and its partners will need to consider (usually through the development of an equalities impact assessment) how best to address various issues relating to its population. For example, it will need to advance equality of opportunity on the basis of ‘protected characteristics’ such as disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex, sexual orientation, marriage and civil partnership.

One example where we have redesigned services to match local health need is described below:

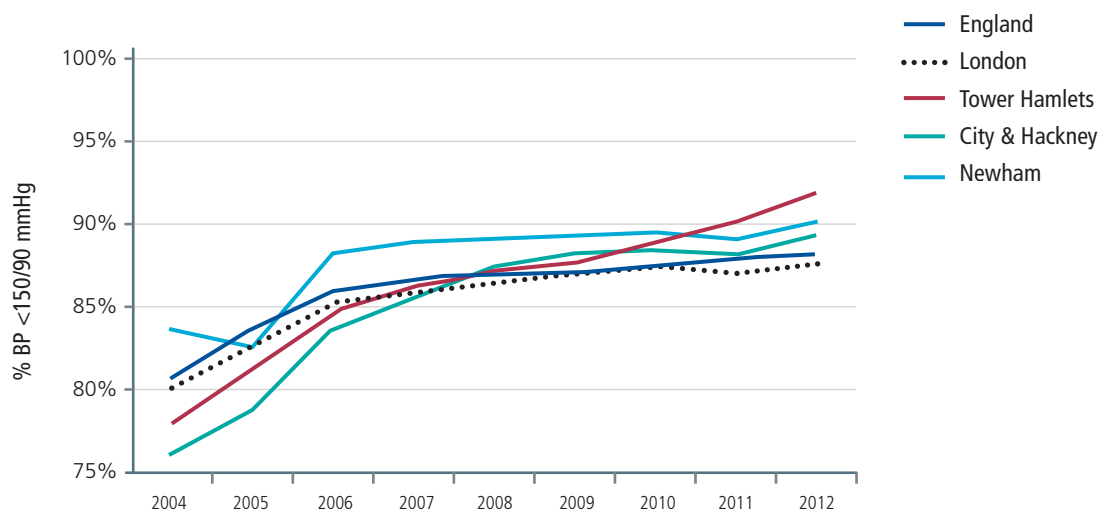
Case study: High-quality and innovative prevention and disease management

Patients in the area who have had a stroke, have diabetes or have heart disease and who need their blood pressure and cholesterol managed, benefit from:

- One of the country's best (top 10) services in Tower Hamlets
- London's second best service in Newham
- The fifth-best service in London in City and Hackney (and the best service in London for atrial fibrillation anticoagulant use)

This success has been supported by the Clinical Effectiveness Group based at Queen Mary University of London, which provides guidelines, education, data-entry templates and other 'on-screen' support tools alongside dashboard feedback on practice-level progress.

% Coronary heart disease: blood pressure <150/90mmHg



Waltham Forest was not part of this original case study, which was commissioned by East London and the City Primary Care Trusts

6.4 Improving the population's health requires a co-ordinated partnership approach

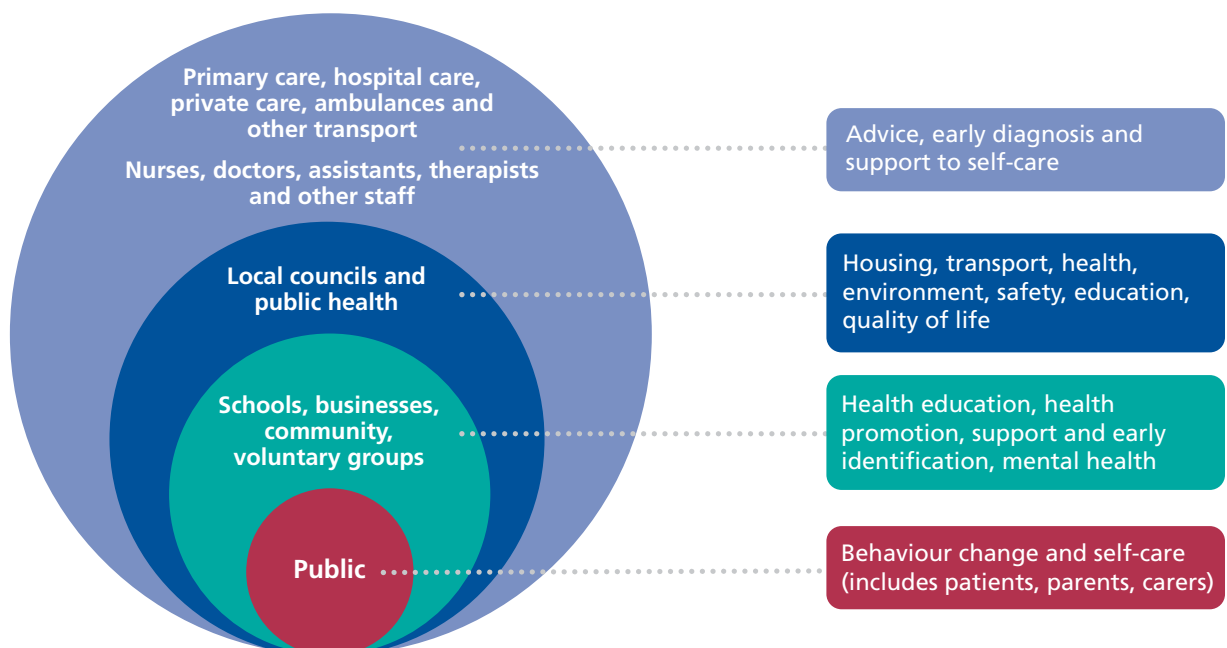
Having a healthy life depends mainly on social, economic and environmental factors. So changing the way we provide health services can only go some way to tackling poor health in the population and health inequalities. As the diagram below shows, significant improvement will require a co-ordinated approach involving the NHS, local government, providers of education, the private and voluntary sector as well as the public themselves.

Patients and the public told us that they (and often the NHS) were confused about:

- relationships between the NHS and other services e.g. when (and if) patients can use private sector providers; who provides hospice and nursing home care; how the voluntary sector is involved
- relationships within the NHS. For instance how primary care refers patients to hospital care.

A lack of clear, concise information (in a variety of formats e.g. paper, electronic and face-to-face) was identified as a key issue. Understanding the system is essential if the NHS is to deliver the requirement to enable patient choice and help patients take control of their own care. A better understanding of the system will be needed to enable people to make good choices in future e.g. with personal health budgets.

Good health, excellent disease management and a speedy recovery if you become ill is everyone's responsibility



Health and wellbeing boards (HWBBs) are the bodies in each borough whose job is to improve health. The local NHS knows it can work harder with other stakeholders to make these boards more effective and help co-ordinate the approach to improving people's health.

The NHS and patients both have obligations under the NHS Constitution

The NHS Constitution sets out patients' rights and obligations. The NHS sometimes falls short on some of these. For example:

- Sometimes the NHS relies on an over-medicalised and paternalistic model that seeks to 'fix' patients rather than empowering them to make choices about health and healthcare
- Sometimes people wait too long for treatment.

At the same time, sometimes patients don't keep their side of the bargain. For example:

- Half of medication prescribed for long-term conditions is not taken or not taken as prescribed
- Between 5% and 10% of people do not attend their GP appointments; for hospital outpatients it is about 19% (above the national average)
- Measles, mumps and rubella (MMR) vaccination rates range from 72% in Newham to 93% in Tower Hamlets
- In 2013, 12% of Barts Health and Homerton Hospital staff, 13% of North East London NHS Foundation Trust (NELFT) and 22% of East London NHS Foundation Trust (ELFT) staff reported physical violence from patients, relatives or the public in the last year.

The NHS, local government and providers of education must do more to help the public help themselves. For example:

- Better, clearer information about medication could reduce wasted prescriptions
- Better, more targeted communications could reduce the number of people who do not register with a GP
- Better use of information technology could reduce the number of wasted appointments
- Involving patients more in the design of services would ensure they are more patient-centred
- Children need to be empowered to take control of their own health through closer working between the NHS and schools.

7 Do all patients benefit from a consistently world-class service?

The way people live has changed a lot in the past 20 years. Alongside this have been advances in technology and healthcare.

As a result, we can help people get better faster when they are ill, and treat people safely closer to their own home. Some advances have helped us live longer, but as a result we often have more complex healthcare needs.

Recent healthcare developments mean we are moving towards a way of working that takes into account more than simply a person's healthcare needs, and sees them as a whole person. This includes empowering people to live fuller lives and make more informed choices about their health. The NHS needs to work harder to support people to use the health system responsibly.



There are great examples of world-class services in east London. We also have some of the country's best clinical staff. But often the way services are set up means we can't provide excellence everywhere. As stated in the previous section, east London's population is growing rapidly and will continue to do so. We know our population brings with it unique problems, meaning we need to go further than elsewhere in the country in our innovation and service improvement. To do this, it is vital we understand what is needed to provide high-quality, sustainable care for everyone.

Patient experience

The Patients' Perspective – the introduction to this document from the patient and public representative group – shows the importance that patients place on their experience of care. The group made it very clear that patient experience is the key to better health and clinical outcomes. The group (and respondents to the engagement) urged clinicians and decision-makers to look at everything from a patient's point of view. For instance:

- if we reduce waiting times of many months and the number of cancelled appointments, some patients will suffer less pain, have a better chance of recovery – and get well again quicker
- if we communicate better, patients will take more control of their own care, perhaps seeing their GP with symptoms earlier when the chances of successful treatment are greater
- if we review complaints better, there will be fewer repeated mistakes.

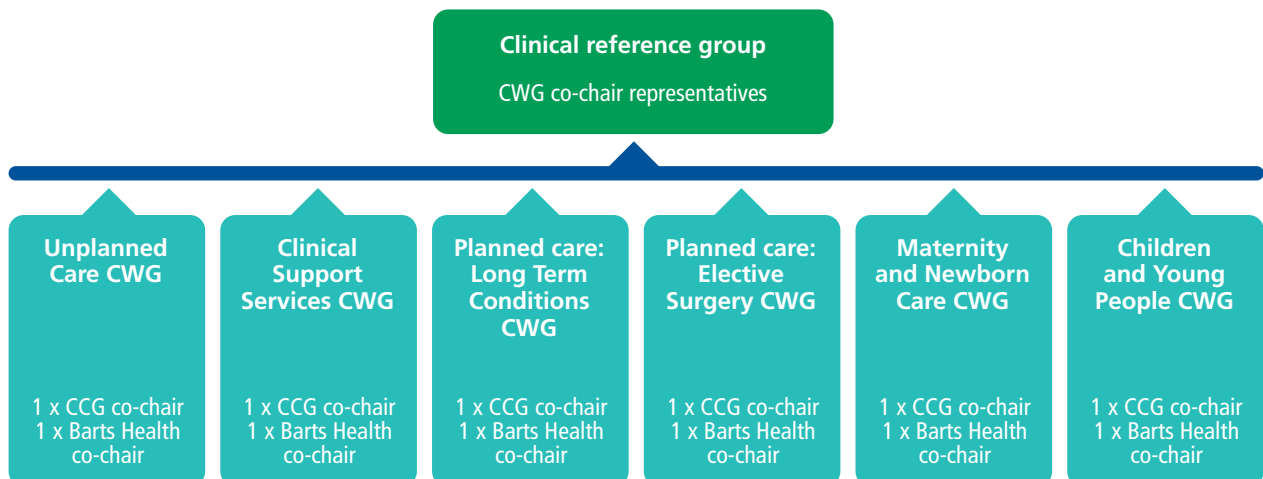
So it is essential to place patient experience (and the patient voice) at the heart of our redesign of services.

Accessible services

Too often there is a lack of information and a shortage of advocates to help patients put forward their point of view. There are inconvenient opening times, long waiting times and complex referral processes. A few services are not available to some people because of where they live. This means that, however good the NHS's services are, patients simply cannot benefit from them.

Six clinical working groups developed the clinical *Case for Change*

To develop a detailed understanding of where there are opportunities to improve and work in new ways, we brought together six groups of clinicians. Each of these clinical working groups (CWGs) focused on a different clinical area.



These clinical working groups were set up to ensure that the programme and emerging *Case for Change* were shaped and underpinned by strong clinical leadership and a strong local understanding to develop the emerging evidence base. In writing this *Case for Change*, the groups considered:

- Patient-experience information
- Best-practice information, policy and guidance (including NICE guidance)
- Their own shared clinical experience
- The best available local data on current performance and activity from local providers and national sources. Different coding and submission practices among providers will always create limitations to this data. But it was felt that group members, patients and the public should have access to it.

These groups also talked with over 350 local clinicians in all healthcare settings to test and validate their work.

Based on the above sources, we asked the groups to consider:

- An overview of currently available services
- The effect of local population changes and demographics on the services
- The implications of local strategies and plans
- What high-quality, sustainable care will look like in future
- How current services compare to this vision
- What obstacles exist to achieving the vision
- The emerging model of care and priority areas for improvement

Improving mental health and primary care were considered within each group, as we know that improving these parts of the health service will lead to better outcomes in all clinical areas.

The clinical working groups focused their discussions on high-quality, sustainable services for the future. But they also recognised the current operational challenges faced by hospitals on such things as cancer waiting times, referral-to-treatment times, and A&E waiting times. Each clinical working group recognised that programmes already exist to improve performance in these crucial areas.

The next section provides an overview of recurring themes from all clinical working groups, as well as an overview of how primary care and mental health care need to change in order that high-quality, sustainable services can be provided in the future.

Summarised findings from each of the clinical working group are outlined from page 63 and the full reports of each clinical working group are in the appendices to this document. Each of the clinical working group's summarised findings is structured in the following way:

- i. **Context:** an overview of current local services and current and future demand
- ii. **The case for change:** including agreed principles of what good care looks like and details of what needs to change. The case for change is summarised at the beginning of each section.
- iii. **Emerging priorities and models of care:** detailing our aspirations for the future

7.1 Recurring themes from all clinical working groups

- 1 **There are pockets of excellent clinical care, but there is too much variability**
- 2 **We must focus much more on preventative services to reduce future pressure on hospital services**
- 3 **Technology should be used widely to deliver more efficient and effective care**
- 4 **Working together with partners to develop more integrated care will improve both quality and efficiency**
- 5 **Patient experience is not consistently good enough**

1 **There are pockets of excellent clinical care, but there is too much variability**

We have pockets of excellent clinical care but the quality of health services across east London varies too much, often because of:

- where patients live (i.e. what services are available to patients in different areas). For example, different arrangements exist for patients to be transferred when they need more specialist care in each borough
- the time of the day or week patients need care.

This variation does not directly reflect on the skills of clinicians themselves. It is often an unintended result of the limits of the systems in which they work.

The clinical working groups agreed that the variation highlighted the opportunity to improve care on different sites and across north east London by working together across hospital sites and organisational boundaries.

**“Many of the messages
[in the *Case for Change*] echo
the work [underway] locally in
Tower Hamlets”**

***Tower Hamlets Health and
Wellbeing Board***

2 We must focus much more on preventative services to reduce future pressure on hospital services

Throughout the process, patients and clinicians have said we need to focus more on preventative services. Every time clinicians talk to patients, they could refer them to a preventative service. This may be to help them stop smoking, to promote good mental health or to support them to lead a healthier lifestyle. Over time this will reduce the pressure on hospital services.

3 Technology should be used widely to deliver more efficient and effective care

There are significant opportunities to increase the efficiency and productivity of healthcare services. To reduce waste, we have heard that we need to improve administrative, IT and operational arrangements. But we also know we are already taking opportunities to use modern technology to improve services. Radical new types of care are already in place, which are both clinically effective and efficient. For example Skype is being used in Newham to give diabetes care to patients remotely.

This Case for Change enables commissioners and providers to explore new ways of working to modernise the way the healthcare system works in east London and provide a system that is clinically and financially sustainable.

4 Working together with partners to develop more integrated care will improve both quality and efficiency

We have an opportunity to deliver improved care through integrating services across east London.

For health, care and support to be 'integrated', it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving to a more holistic approach to health, care and support that puts the needs and experience of people at the centre of how services are organised and provided.

Patients can sometimes face poorly coordinated services. Clinicians tell us they are frustrated with how information is transferred and shared across organisations. We also know that to truly integrate care we must fully involve patients in their own care. For example, personal health budgets have allowed patients to bring together and take control of services to achieve the improvements in health they want¹².

We know work is being done to improve integration that has already achieved success. We now need to rapidly expand this work as it is a great opportunity for us as providers and commissioners to work together to improve local healthcare.

12 National Voices (2013): A Narrative for Person-Centred Coordinated care, <http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf>

5 Patient experience is not consistently good enough

Understanding patient experience of clinical services has been central to developing our Case for Change. Each of the clinical working groups carefully considered the feedback received from patients and their families. For a summary of our wider engagement, please see section 4.

Patients tell us that patient experience of healthcare services in east London varies, and that it is not consistently good enough. Many people commended the excellent services and staff in the NHS. But we have also heard of many instances when care and services have fallen short of expectations.

Patients explained that the NHS sometimes seems to regard patient experience and clinical care as separate things (with patient experience seen as less important). Patients overwhelmingly viewed their care in a much more holistic way.

Poor communication leads to poor patient experience, worse outcomes and waste. Communication and poor patient experience of care were the most common issue raised by patients and the public. Sometimes this just causes irritation (for instance, delays in outpatients). But sometimes it is linked to poorer outcomes (e.g. cancellations of operations) and results in wasted resources (e.g. in re-booking theatre times or multiple diagnostics because previous tests cannot be accessed or have been mislaid).

There was some evidence of where things hadn't worked and patients' wellbeing could have suffered, for example not being fed for long periods while in hospital or having treatments delayed because scans weren't available at the right time. The local NHS must act on this.

Patients highlighted the need for more coordination, and for clearer information about available services. Many found the health service hard to navigate and were not always sure what treatments were available to them. This was especially true when they needed urgent care.

"Concerned about the NHS working in silos – will this break these down?"

Redbridge Health Scrutiny Committee

"Clinicians and departments need to talk to each other more"

Attendee at long-term conditions focus group



Some people found they were having to travel to a hospital for multiple appointments about the same issue. Some of these tests could have been done closer to home.

Sometimes patient and clinician time is being wasted by inefficient administration, resulting in long waiting times and cancelled appointments at very short notice.

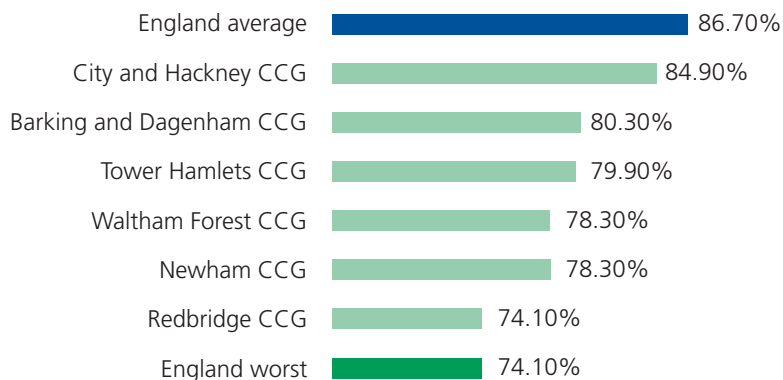
Often respondents felt confused as their care was not integrated and they were left in a bureaucracy that passed them from pillar to post. Nationally available data reflects these local stories. So we know we must do better in all care settings.

Accessing GP care could also be improved. Current data shows that in London, GP patient satisfaction scores are low for access and for seeing a GP of choice. This includes getting through on the phone and booking appointments. No CCG in north east London meets the England average for patient satisfaction.

Surveys of patient experience of acute care services also show low scores in east London. Barts Health has lower than national average scores on inpatient, A&E and combined friends and family scores. The biggest variation is in A&E where Barts Health scores 48 compared with a national average of 57.

Out of 22 London hospital maternity services, Barts Health is ranked 19th and Homerton Hospital 21st¹³, although a recent CQC inspection of maternity services at Homerton Hospital rated the services as good.

Satisfaction with general practice using NHS outcome framework indicator: "Patient experience of GP services, percentage whose experience is very good or fairly good." July 2012 to March 2013.¹⁴



¹³ Care Quality Commission (2013)

¹⁴ Health and Social Care Information Centre <https://indicators.ic.nhs.uk/webview/>



Case studies: examples of world-class services

Across east London we have examples of world-class health services. We know there is an opportunity to replicate these examples:

- **Patients in Newham** are being supported to manage their diabetes via Skype appointments.
- **Social prescribing**, a scheme that links patients with non-medical sources of support in the community, is being used effectively in Tower Hamlets to provide preventative care in partnership with the voluntary sector.
- **The Barts Health clinical biochemistry team** recently won the national Patient Safety in Diagnosis Award.
- **GPs in Waltham Forest** can now test for heart failure using B-type Natriuretic Peptide (BNP) testing, saving patients a trip to the hospital.
- **The children's hospital at Barts Health** offers a wide range of regionally specialised medical and surgical services including paediatric intensive care within close reach of children of east London.
- **The Royal London Hospital's hyper acute stroke unit** and Whipps Cross and Newham hospital's stroke units provide patients with some of the best care not only in London but across the country.
- **Newham CCG won a HSJ¹⁵ national award for Innovation in Mental Health** for their work in connecting with young people during Mental Health Awareness Week. The CCG collaborated with a local youth radio station to run a campaign on eating disorders, drugs, depression, teenage anxiety and bullying.
- **The Care Quality Commission** assessed Homerton Hospital's A&E services as outstanding.
- **Doctors at The London Chest Hospital** recently injected a patient's own stem cells into his heart at the start of the world's largest-ever trial of adult stem cell therapy. The aim is to reduce deaths from heart attack.
- **In Barking and Dagenham, Havering and Redbridge**, GPs use individualised patient scorecards to support patients suffering from chronic obstructive pulmonary disorder (COPD) and help them manage their condition.
- **Whipps Cross has an emergency gynaecology unit**, to provide one-stop diagnosis. This has halved associated emergency attendances and reduced waiting time breaches by 80%. Patients now wait less than 48 hours for ultrasound diagnosis, and there have been 84% fewer complaints.
- **In April 2014 the emergency department at Homerton Hospital** was the first in the country to be certified as 'outstanding' after a CQC inspection.
- **Whipps Cross Hospital** uses evidence-based techniques such as fetal fibronectin and transvaginal cervical scans to identify women who are in the early stages of labour. This reduces unnecessary transfers and stays in hospital.

7.2 Primary care in east London: facing unprecedented challenges

- 1 **Local primary care clinicians report facing unprecedented challenges, including finances and the growth in demand**
- 2 **General practice needs to be supported to play a stronger role at the heart of integrated out-of-hospital services**
- 3 **Working together in networks can help primary care respond to the challenges**
- 4 **There is significant variation in the provision, access, experience and outcomes of GP services in east London**

There is a direct relationship between the way we provide primary care services and the role of our acute services in giving healthcare. This close relationship meant that each clinical working group considered primary care throughout their discussions.

Effective support in primary care will mean fewer people needing to be treated in hospital. For example, clinicians told us that with the right support, more children could be treated closer to home by GPs, rather than needing to travel further to hospitals and taking more time out of school. This would allow paediatricians to spend more time with children with complex specialist needs.

New types of care need to be adopted that meet the needs of patients and prevent ill health more effectively.

1 Local primary care clinicians report facing unprecedented challenges, including finances and the growth in demand

Funding in general practice has been relatively flat with, nationally, a real-terms decline in investment over the last two years. Locally this position is even more challenging due to rapid population growth and a time-lag in funding following this. As with the rest of London, spending on primary care in east London is low (in the lowest 25% nationally)¹⁶.

GPs in east London are also reporting unprecedented demand. Coupled with this is an increase in the complexity of patients' needs in primary care, which local doctors tell us they have difficulty dealing with in the standard 10-minute consultation. We must look at new ways of working that support an expanded primary care role that gives a high-quality service to patients.

"It's brutal out there in terms of the pressure"

East London GP

¹⁶ Monitor, NTDA and NHS England (2013): WELC SPG planning document

2 General practice needs to be supported to play a stronger role at the heart of integrated out-of-hospital services

NHS England wants general practice to play an even stronger role at the heart of more integrated out-of-hospital services that provide better outcomes, more personalised care and excellent patient experience. This role should build on the strengths of GPs such as their generalist skills and the opportunity to successfully manage long-term conditions. The role may involve working together, e.g. in networks, to support better access to convenient and reliable unscheduled care in a way that is highly coordinated, efficient and financially viable.¹⁷

3 Working together in networks can help primary care respond to the challenges

Within current resources, to improve primary care will be a major task that will mean large-scale change. Newham, Tower Hamlets and Waltham Forest practices have formed or are creating networks to help them work together, with greater coordination. Tower Hamlets established its network model in 2009, with the 36 practices in the borough forming into eight networks of four to five practices. The network structure will enable practices to provide economies of scale, and share back-office functions and management. It has also helped Tower Hamlets achieve better immunisation rates and diabetes care.

4 There is significant variation in the provision, access, experience and outcomes of general practice services in east London

For example:

■ Many patients rate their experience of accessing GP services as poor

Patient experience of access to GP services has been rated as poor (in the bottom 25% nationally) for every CCG as measured by the GP patient survey¹⁸. This has been reflected in our engagement work with the public, who have said they find it hard to access general practice and asked for more evening and weekend access. Significant national policy is emerging in this area, including the Prime Minister's Challenge Fund.

■ Some practices do not meet GP outcome standards

A significant number of GP practices in east London do not meet the GP outcome standards. These standards cover a range of GP services, such as screening, diagnosis and patient experience. They represent a level of care everyone should expect to receive from their GP surgery.¹⁹

GP practices also vary in how well they fulfil the Quality and Outcomes Framework (QOF) indicators, for example in identifying people at risk of long-term disease.

■ There is wide variation in the number of GPs in each borough

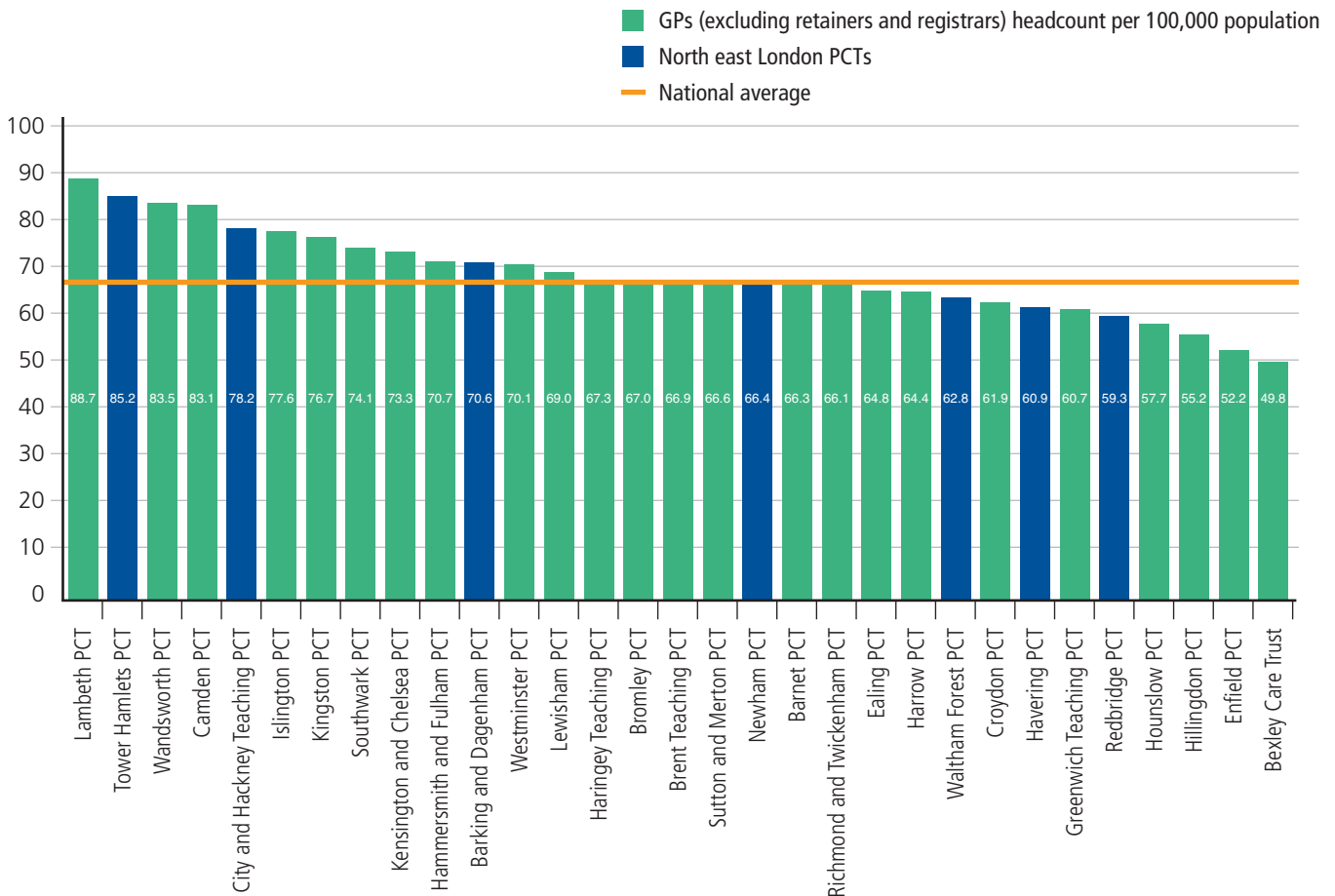
- Tower Hamlets has 86 GPs per 100,000 population – the second-highest rate in London
- Redbridge has 59 GPs per 100,000 population – the fifth-lowest rate in London
- East London has more than the national average of 'small' general practices (one or two GPs).

¹⁷ NHS England (2013): Transforming Primary Care in London

¹⁸ GP Patient Survey (2014)

¹⁹ www.myhealth.London.nhs.uk

GPs (excluding Retainers and Registrars) headcount per 100,000 population London PCTs



Health and social care information centre, 2013. Local basket of inequality indicators, the number of full-time equivalent (FTE) primary care professionals per 100,000 population (weighted for age and need). [ONLINE] Available at <http://www.indicators.ic.nhs.uk/webview/>. [Accessed 5th August 2014].

The workforce challenges faced in general practice are significant and this is discussed further in the workforce section (section 9).

Difficulties in primary care have been central to the discussions of the clinical working groups. The opportunities for improvement and potential for primary care to support new types of care are discussed throughout the *Case for Change*.

Transforming primary care services across east London will occur in a separate workstream of the *Transforming Services Together* programme (see section 10 for more information).

7.3 Tackling mental health needs in our hospitals and healthcare services

Context

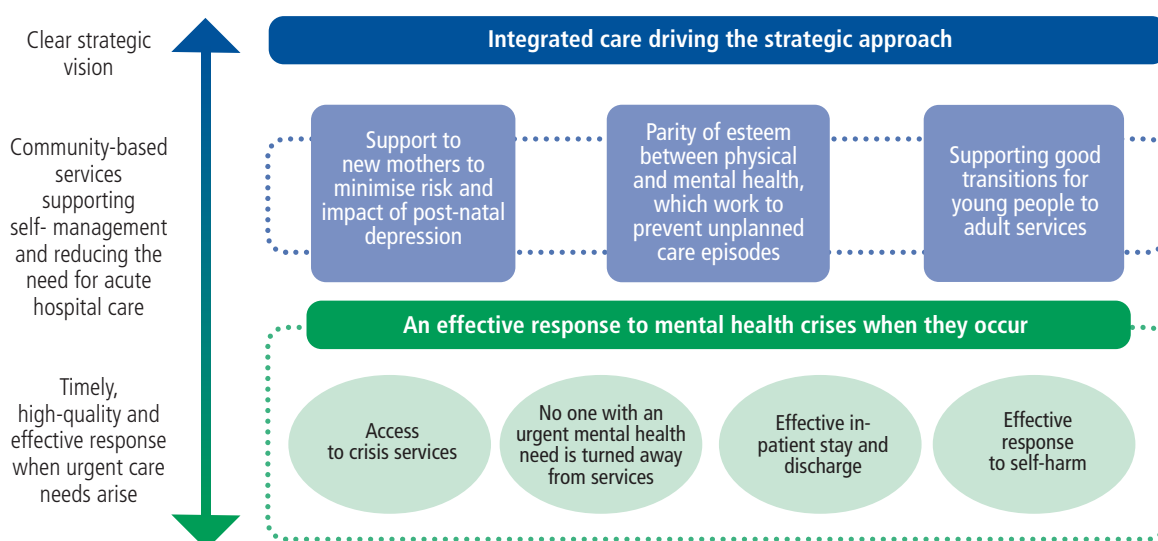
Mental health has been important for each of the clinical working groups, who have put forward their findings. We have also held discussions with clinical and commissioning leads for mental health, as well as providers of mental health services. This section brings all the findings together and looks at how hospital services can effectively meet the mental health needs of people in east London, and how we can provide effective support for people in all healthcare services.

High levels of mental illness in east London

There are high levels of mental illness in east London (in children and adolescents, working-age adults, and older people – including dementia). This may be partly because east London has a high prevalence of risk factors that can contribute to mental illness.

Ensuring parity of esteem between physical and mental health care is vital

Some key principles have emerged from the clinical working groups. These principles are aligned with national policy. They focus on ensuring there is 'parity of esteem' (equality of worth) between physical and mental health. The diagram below shows how all parts of an effective health care system must work together.



Mental health: the case for change

This section details our case for change to tackle mental health needs in our hospitals and health care services.

- 1 Our approach to integrated care should be strengthened regarding mental health so that we provide a more patient-centred model of care.
- 2 By creating parity of esteem between physical and mental health, we can better meet our population's needs. This will help prevent people having a mental health crisis and enable us to respond more effectively if it does occur.
- 3 We need to ensure support is available 24/7 for children and young people with urgent mental health needs.
- 4 We need to ensure that high-quality CAMHS services are in place and that we give good support to young people when they move on to adult mental health services.
- 5 We need to do more to minimise the risk and effect of post-natal depression for new mothers throughout the maternity care pathway.

1 Our approach to integrated care should be strengthened regarding mental health so that we provide a more patient-centred model of care.

Mental health leaders in east London have told us that the areas we need to strengthen within integrated care approaches are:

Vision, leadership and workforce: the vision of integrated care for mental health needs to be strengthened, with a strategy for a workforce that can ensure early identification and response to mental health needs. Everyone providing health and social care has a role in identifying people with mental health needs and supporting their emotional wellbeing or referring them to services that can.

Tackling medically unexplained symptoms: this key area highlights that parity is needed. Community psychiatric nurses (CPNs) are not trained to identify medically unexplained symptoms. This creates a gap for patients with long-term conditions who experience these, which are often a symptom of a mental health problem.

Communication and IT systems: our systems need to support the sharing of care plans between all providers, including mental health.

Evidence-based practice driving the strategic response: we need to ensure that care integration and support for mental health needs are provided in line with NICE guidelines and that these form the basis of the goals and outcomes we seek.

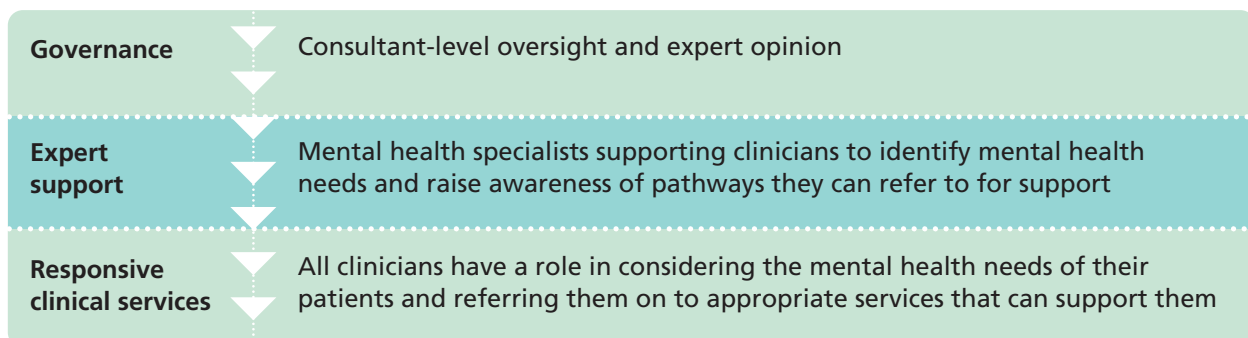
2 By creating parity of esteem between physical and mental health, we can better meet our population's needs. This will help prevent people having a mental health crisis and enable us to respond more effectively if it does occur.

Many people with long-term physical health conditions also have mental health problems, and having mental health problems can worsen a physical illness. This can lead to significantly poorer health outcomes and reduced quality of life. People with a primary mental health need may also have their physical health needs overlooked. Healthcare costs are increased by at least 45% for each person with a long-term condition and a mental health problem²⁰.

Local clinicians have set out the following ambitions for care to strengthen parity of esteem:

- All clinicians should be able to identify and respond to mental health needs
- Mental health should feature as a core aspect of every care plan
- Mental health support for patients with long-term conditions should not complicate the care patients receive (for instance, extra appointments and travel). Care should be coordinated with the wider care plan and a team approach to provision
- Clinicians providing care for people with a physical health condition need to be supported by psychological services and have clear pathways that support onward referral for mental health support
- People should not be in a hospital because there is nowhere else for them to go. This is currently the case for many patients with dementia
- The end-of-life care principle for long-term condition care should have a strong mental health focus on emotional support and managing wellbeing in the last years of life.

A type of care that local clinicians thought was effective in providing mental health support for people with long-term conditions was described as having the following structures and levels of support:



²⁰ The Kings Fund (2012): Long-Term Conditions and Mental Health – the costs of co-morbidity

“Physical health and mental health should be treated together as they are connected”
Newham female resident, aged 41-65

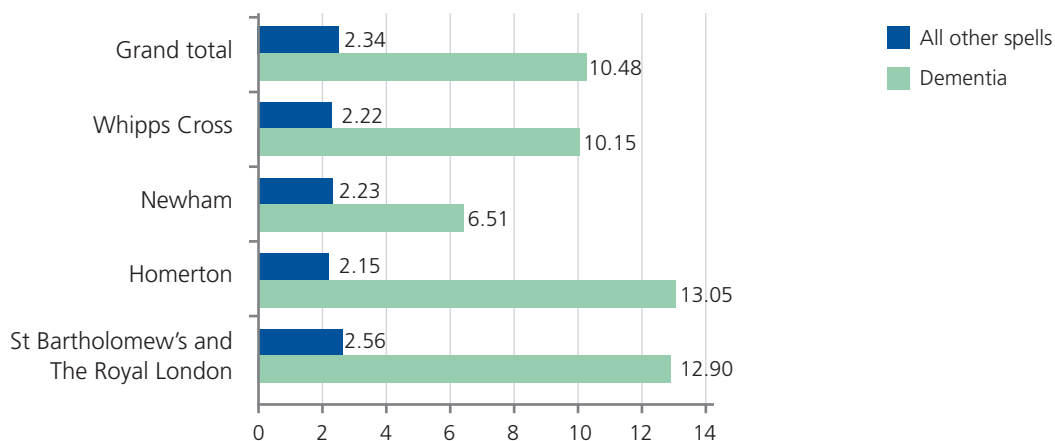
In east London we do not achieve this type of care. There is some good practice, such as the respiratory nurse team in Tower Hamlets, which does anxiety assessments as part of the care it gives patients. But good practice needs to become routine across east London.

Patients with a diagnosis of dementia are spending significantly longer in hospital than patients with other conditions. For most trusts the average length of stay was up to 10 days longer for people with dementia than the average length of stay for all other conditions (unplanned and planned care admissions). This can be seen in the graph below.

In addition, dementia patients account for 2.84% of hospital spells at Whipps Cross Hospital, yet account for 11.8% of their bed days²¹.

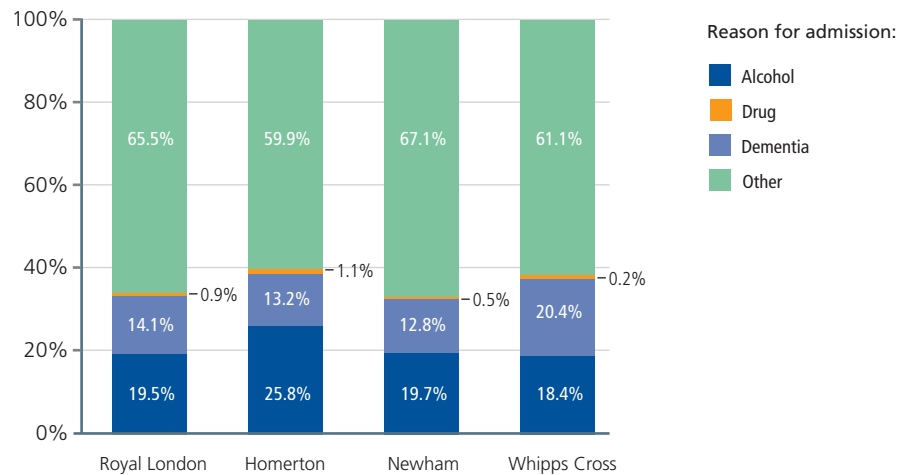
Mental health is the third most common reason for emergency (non-elective) admission into our hospitals among 19-69 year olds. Between a fifth and a quarter of admitted patients are diagnosed with a mental health condition. Alcohol-related problems and dementia feature heavily.

Average length of stay for patients with a diagnosis of dementia (diagnosis code 1-20) April 2013 – March 2014, planned and unplanned care admissions (SUS)

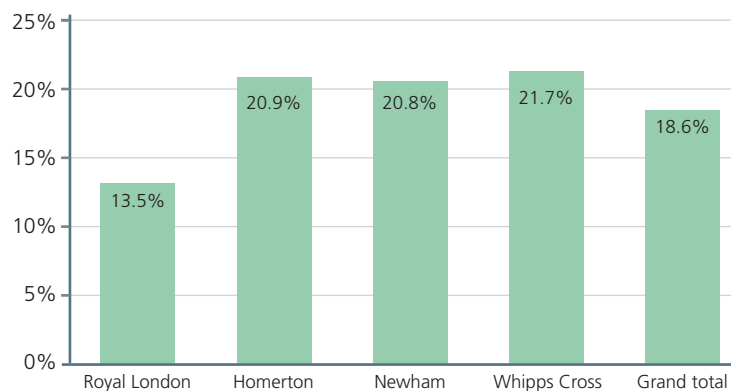


21 SUS April 2013 - March 2014

Reasons for non-elective hospital admissions (for patients with mental health diagnosis) 1 April 2013 to 31 March 2014



Non-elective admissions with a mental health diagnosis as a proportion of the total non-elective admissions 1 April 2013 to 31 March 2014



The Rapid Assessment, Interface and Discharge (RAID) service offers support to specialists in acute settings. Alongside raising awareness of mental health across the entire workforce, awareness of this service needs to be promoted. The Academy of Medical Royal Colleges (2014) has stated that the NHS could save up to £568 million a year through improved liaison with psychiatric services²².

Two important issues are in-patient care for those with alcohol and substance misuse problems, and unplanned episodes of care because of domestic violence. To support people with these needs, our partnerships with local authorities need to ensure there are effective local, community-based services. These can provide an alternative to hospital-based care in a better recovery setting.

²² Association of Medical Royal Colleges (2014): Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care



3 We need to ensure support is available 24/7 for children and young people with urgent mental health needs.

Acute sites have different ways of responding urgently to children and young people who attend A&E with a mental health need, particularly out-of-hours. It is common practice that, out-of-hours, children and young people will be seen by a psychiatrist for adults. There are opportunities to make this better.

4 We need to ensure that high-quality CAMHS services are in place and that we give good support to young people when they move on to adult mental health services.

Children and Adolescent Mental Health Services (CAMHS) are commissioned in a fragmented way. Clinicians have told us this needs to be improved. They raised specific concerns about services in schools. They noted increasing variation in services, particularly in free schools²³.

When young people reach 18, they move on to adult services. This transition is often poor and can lead to them falling out of the system. Local CCGs are tackling this by reviewing and reorganising CAMHS. They are considering extending the age limit to 25.

5 We need to do more to minimise the risk and effect of post-natal depression for new mothers throughout the maternity care pathway.

In east London we have good services for new mothers with high-level mental health needs, but we lack effective services for those whose needs are low to medium level. At present, care is provided by the Improving Access to Psychological Therapies (IAPT) service. As there are different types of care across the boroughs, IAPT does not always provide a fast and integrated response. In addition, mental health and emotional support is not currently embedded in the antenatal care pathway.

Emerging priorities and types of care for better mental health

Based on analysis by the clinical working group and clinical leaders for mental health, we have set out below the main emerging priorities and types of care. These will need to be discussed and taken forward in the *Transforming Services Together* mental health workstream (see section 10 for more information):

- Ensure that the vision and strategy for integrated care delivers parity of esteem for mental and physical health needs, e.g. all care plans consider mental health needs
- The health and social care workforce need to be trained to recognise and identify suitable support for mental health needs, helped by experts in mental health care
- We need to better support new mothers with low to medium mental health needs
- We need to ensure suitable support is available 24/7 for children and young people with urgent mental health needs.

²³ A free school in England is a type of academy, a non-profit-making, independent, state-funded school which is free to attend but which is not controlled by a local authority

7.4 Maternity and newborn care

This section summarises the findings of the Maternity and Newborn Care Clinical Working Group, giving an overview of the context that local services are operating within, the case for change and emerging priorities and models of care for the future.

Context

The birth rate in England is rising, with a 23% increase in babies born between 2001 and 2012 to reach the highest annual number of births since 1971²⁴.

Since 2008, average annual growth in births locally has been high, up to 2.7% in some boroughs. We now have some of the highest birth rates in the country with more than 31,000 births across the seven north east London CCGs in 2013²⁵.

There are likely to be almost 5,000 more births a year in north east London by 2023-24

We have every reason to believe that the number of births in the area will continue to increase in the next decade. The largest population growth is forecast to be in people of working age. It follows that if the fertility rate remains high, the number of births will continue to rise as new families move to the area.

We have predicted the births by borough by applying the average fertility rate for each borough for 2011-13 to the forecast population of women of child-bearing age. The figures are shown in the table on the next page and show:

- Births in north east London are likely increase by 4,882²⁶ a year in the ten years up to 2023-24. The total number of births is likely to be close to 36,400.
- The area of greatest increase is likely to be Tower Hamlets and Newham, where the forecast population increase is the largest.
- This is likely to carry on for a further ten years given population growth forecasts. Potentially there could be 40,000 deliveries a year across north east London in 20 years' time.

²⁴ Royal College of Midwives (2013): State of Maternity Services report 2013

²⁵ Office for National Statistics (ONS)

²⁶ Forecasts are local calculations based on GLA methods using ONS's most recently published predictions of fertility rates. There is significant variation in the various birth forecasts available. The figures used represent one of the higher forecasts. Further work will be needed on birth forecasts.

	Total births 2013-14	Forecast 2023-24	Increase	% Increase
Tower Hamlets	4,608	6,080	1,472	31.9%
City & Hackney	4,500	5,142	642	14.3%
Newham	6,267	7,615	1,348	21.5%
Waltham Forest	4,721	4,862	141	3.0%
Redbridge	4,591	4,941	350	7.6%
Barking & Dagenham	3,796	4,252	456	12.0%
Havering	3,004	3,477	473	15.7%
Total	31,487	36,369	4,882	15.5%

Births are becoming increasingly complex, with more pre-term births and high rates of full-term babies with low birth weight

Complex pregnancies in the region are putting more demand on health services. There is a rising trend of pre-term births, which is placing more pressure on neonatal services. In addition, improvements in medical practice are resulting in more demand for care for very premature babies.

East London also has high rates of low birth-weight babies at full term, with rates as high as 10.1% in Newham compared to the England average of 7.3%²⁷.

Pre-existing health conditions also contribute to more complexity in pregnancy. For example, east London has a higher prevalence of obesity than the London average (9.9% compared to the London average of 9.2%²⁸). Diabetes prevalence in the adult population is high and rising in some parts of east London, with prevalence rates forecast to rise to 10.4% in Newham by 2015 against a forecast England average of 7.6%²⁹. The prevalence of mental health conditions in east London is higher than the England average, meaning that more care is needed for women during the antenatal and postnatal period. Rates of poverty and family homelessness³⁰ are worse than the England average, which can lead to poor nutrition and poorer health outcomes.

27 Public Health England (March 2014): Child Health Profiles

28 McKinsey (2012): Developing the case for change in establishing an Integrated Care System across Waltham Forest, East London and the City

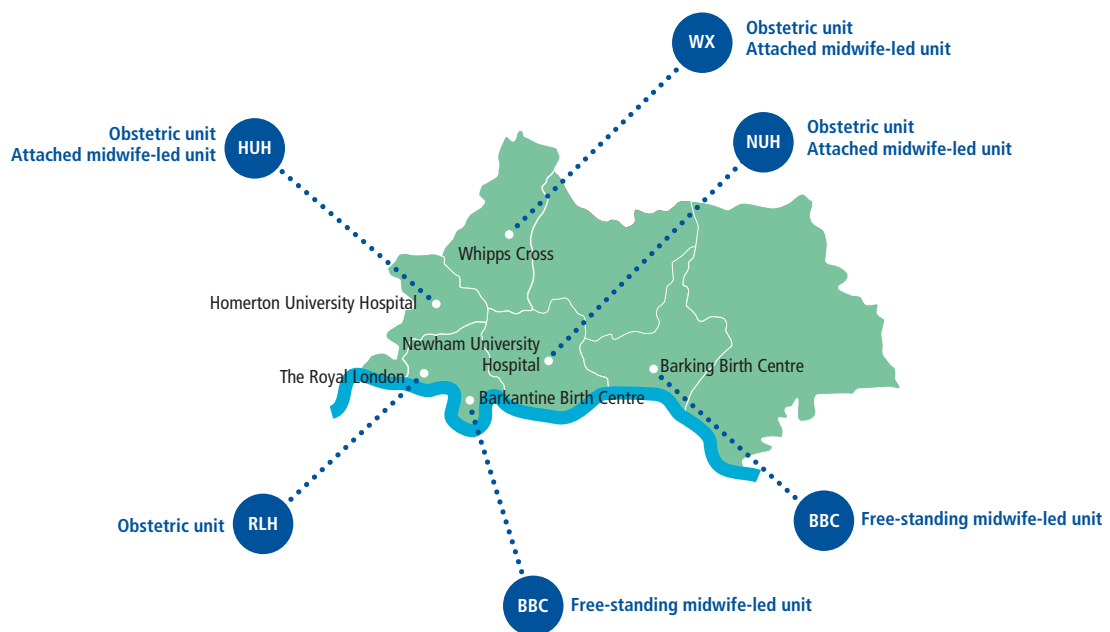
29 LTC CWG data pack

30 Public Health England (March 2014): Child Health Profiles

Maternity services in east London are delivered by a large number of providers across multiple sites

The map below shows the current set-up of obstetric and midwifery-led units across Homerton Hospital and Barts Health. Homerton, Newham and Whipps Cross hospitals all have obstetric units, with midwifery-led units operating alongside them. The Royal London Hospital has an obstetric unit with a midwifery-led unit planned to open later this year. Barts Health has two free-standing (not co-located with a hospital) midwifery-led units, the Barking and Barkantine birthing centres. There are also many community providers, GPs, local authority services and independent organisations providing antenatal and postnatal care and family support services.

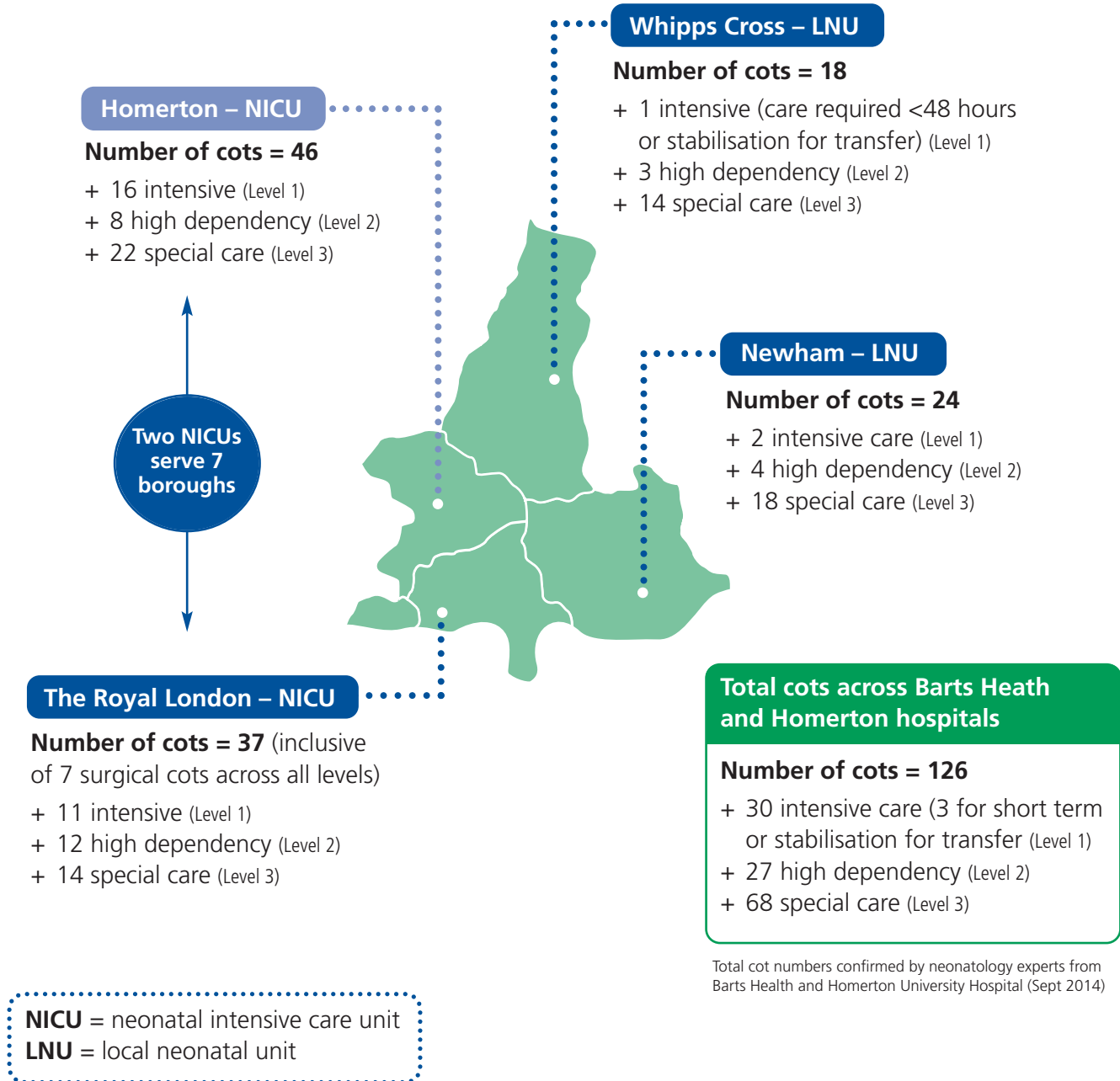
Maternity units in east London and the City³¹



As the map on the next page shows, there are four neonatal units across Barts Health and Homerton Hospital. Two are designated 'level 2', giving high-dependency care to newborns. The Royal London Hospital and Homerton Hospital are 'level 3' units, giving intensive care to newborns. The level 3 units serve all seven boroughs in north east London.

³¹ Including Barking and Dagenham

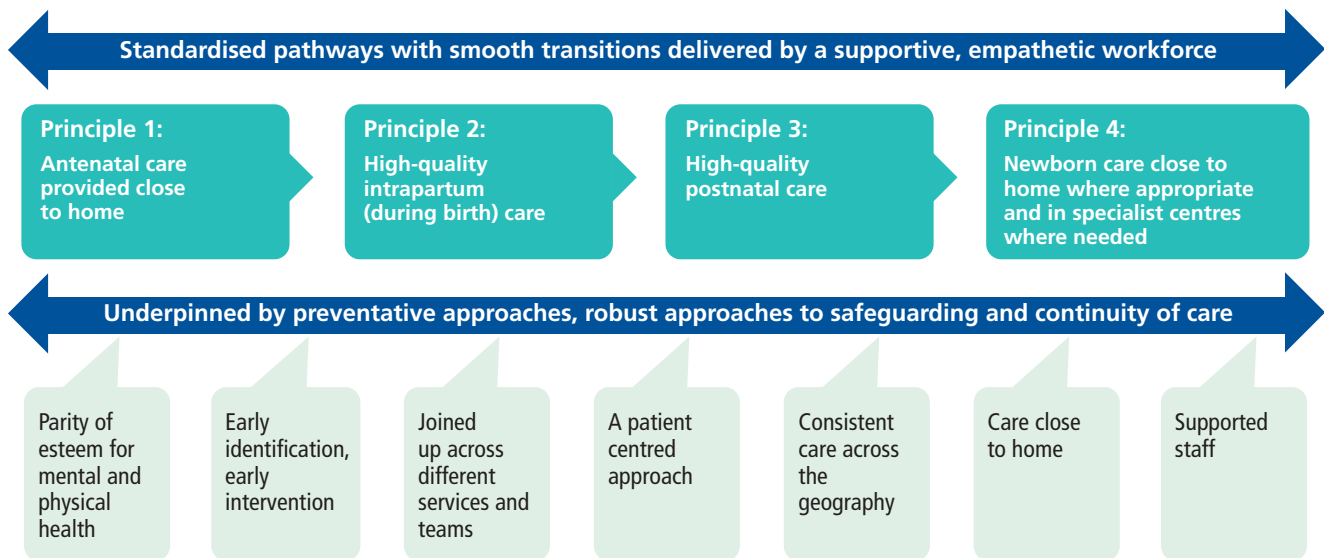
Current set-up of maternity units in east London



Maternity and newborn care: the case for change

- 1 We can reduce the number of women having complications during birth by increasing the number who start their antenatal care early.
- 2 Effective 'mapping' of antenatal care across east London can help ensure all women are seen by the right healthcare professional in the most suitable setting.
- 3 Integrating health care with local authority services and support groups would improve the support available to women.
- 4 We need to work together to ensure we are prepared for the additional births across north east London.
- 5 Midwifery-led deliveries should be the norm for births. This enables us to continue providing women with a choice of where they have their baby that is suitable to their level of risk.
- 6 New ways of working mean we could ensure more women have a natural birth and reduce the number who have interventions such as emergency caesarean-sections (c-sections).
- 7 It remains difficult to meet best-practice staffing levels across east London for obstetrics and midwifery.
- 8 We know we need to improve postnatal care. We want to standardise it across east London and improve the communication between hospitals, GPs and community services.
- 9 We need to do more to minimise the risk and effect of postnatal depression for new mothers throughout the maternity care pathway.
- 10 We need to develop ways of measuring and benchmarking neonatal care in east London to ensure it is of high quality.
- 11 By standardising neonatal care pathways and protocols and transitional care, we will be able to ensure that babies can return home as soon as it is safe and that unwell babies continue to be cared for safely.
- 12 Capacity and capability in neonatal care and its workforce will need to increase to meet demand more effectively.
- 13 Through developing stronger consistent pathways and transfer protocols, we can provide more efficient and effective neonatal and paediatric services.
- 14 There is interdependency between how neonatal demand is managed in east London and how babies are transferred from one neonatal unit to another. This includes transport arrangements and clinicians required to travel with the baby. Any recommendations about future types of neonatal care must take into account the effect on neonatal transport arrangements.

We have developed the case for change by comparing current services with principles that the Maternity and Newborn Clinical Working Group set out for good care:



This section describes our case for change:

1 We can reduce the number of women having complications during birth by increasing the number who start their antenatal care early.

Women should start their antenatal care as early as possible to maximise the benefits of healthy living during pregnancy and to help us identify and monitor risk factors as soon as possible.

National Institute of Clinical Excellence (NICE) guidance recommends that pregnant women are supported to access antenatal care, ideally by 10 weeks after conception³².

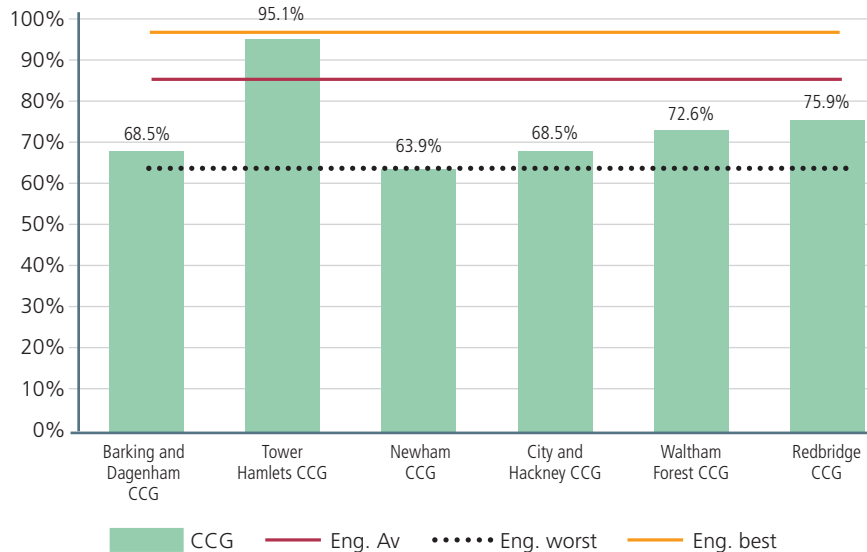
The 13-week booking indicator shows us that too few women in north east London³³ are starting their antenatal care early enough and that there is too much variation across our CCGs. The rate of women starting their antenatal care by 12 weeks ranges from 63.9% to 96.1%, against an England average of 86.2% (see table on next page). If problems are not identified early enough, there can be risks or complications.

³² National Institute of Clinical Excellence (2008): Clinical guideline 62

³³ Excludes Havering

Antenatal assessment under 13 weeks: London comparison 2012-13

Source: The Information Centre for Health and Social Care 2012-2013



2 Effective 'mapping' of antenatal care across east London can help ensure all women are seen by the right healthcare professional in the most suitable setting.

There is no central mapping of antenatal activity in east London. But the clinical working group believes that provision is highly variable, with too much activity taking place in hospitals which would be more suitable in primary or community settings. NICE recommends that midwives and GPs should care for women with uncomplicated pregnancies and that antenatal appointments should occur in places that are readily accessible and well suited to the needs of women and their community³⁴.

*Health for north east London (Health for NEL)*³⁵ recommended that 95% of antenatal and postnatal care should be available outside hospitals. So based on the current number of women giving birth, 16,200 bookings a year would need to be managed in community or GP settings and 850 managed by hospitals³⁶. *Health for NEL* has shown that achieving this is complicated by the existing commissioning arrangements and financial incentives.

Further complications exist with a shortage of midwives and variability in GP skills and knowledge. There is a national shortage of qualified midwives³⁷ and this is a particular problem locally. Shifting care out of hospitals would mean more midwives working in the community, not in hospitals.

34 National Institute for Clinical Excellence (2008): Clinical guideline 62

35 *Health for north east London* was a transformational change programme, clinically led and with extensive public engagement, to reorganise hospital services within North East London. This programme's recommendations (endorsed by the Secretary of State for Health in 2010) provide a key reference point for planning and developing hospital services in north east London. <http://www.eastlondon.nhs.uk/About-Us/Trust-Board-Meetings/Trust-Board-Meetings-2010-docs/Jan-2010/HealthforNorthEastLondonConsultation.pdf>

36 SUS data

37 Royal College of Midwives (2014), State of Maternity Services report 2013

The shortage of midwives brings difficulties in providing continuity of care by a named midwife, as recommended by NICE³⁸. The clinical working group believes all providers should give pregnant women a named and known midwife to ensure continuity and care and more effective integration among antenatal care providers. However, only Homerton Hospital currently does so.

Given the rising fertility and birth rates, the increasing demand for deliveries in obstetric units and difficulties in recruiting to vacant midwifery posts, acute services are also finding it hard to give all pregnant women the same levels of access to antenatal group support.

3 Integrating health care with local authority services and support groups would improve the support available to women.

The clinical working group believes that services are poorly integrated. The barriers to integration and effective communication are the wide variety of providers in health, social care and voluntary organisations, the lack of a directory of services, and the lack of a shared electronic care record.

The group recognises that a healthy pregnancy is supported by organisations beyond the NHS, particularly in preventative medical services. However, this support should be coordinated so that it is easy for women to know about and receive the services they need.

Women in east London report variable experiences as to the information they receive about their options. Women have told us they sometimes 'found out by accident' what assessments should happen and when, and what support is available to them – for instance, by friends asking why they hadn't yet seen a midwife. This is a particular concern among women from deprived backgrounds, as evidence suggests they are more likely to face difficulties accessing services.

"We want more information about range of options for where to give birth"
Attendee at maternity and newborn care focus group

"Not enough breastfeeding support – you don't always want to leave the house to go to the children's centre"
Attendee at maternity and newborn care focus group

38 National Institute of Clinical Excellence (2008): Clinical guideline 62 recommendation 1.2.2.1

4 We need to work together to ensure we are prepared for the additional births across north east London.

Given the opening of a new midwifery-led unit (due later this year) alongside The Royal London Hospital obstetric unit, there is currently enough physical capacity across the Barts Health and Homerton campuses to meet current demand (see table below). The new facilities at The Royal London Hospital will increase capacity on the site to 6,000+ deliveries a year.

However, we need to work together to ensure we are prepared for the additional births forecast across north east London. A new system of managed flow is smoothing demand across the five maternity campuses. The clinical working group found this new system was successful but also saw that women will often attend for delivery at a different site from the one they were booked in for. This can make it difficult to manage capacity and demand.

Physical capacity in east London and the City delivery units

Unit	Capacity		2013-14 deliveries	Pinch point	Commentary
	Per year	Average per week			
Royal London	4,850	93	5,539	Obstetric delivery rooms - postnatal beds	New midwifery-led unit planned that will increase capacity to 6,000 deliveries
Whipps Cross	5,200	100	5,074	Midwifery-led unit and obstetric delivery rooms	Long-term plan to increase capacity in the unit
Newham	7,100	137	6,727	Obstetric delivery rooms	Requires 22% of hospital births in midwifery-led unit and 350 births in Barking Birth Centre
Homerton	5,900 (now 6,200)	113	5,976	Postnatal beds	Number of postnatal beds have been increased and this has increased capacity to 6,200

If births continue to increase as predicted, then:

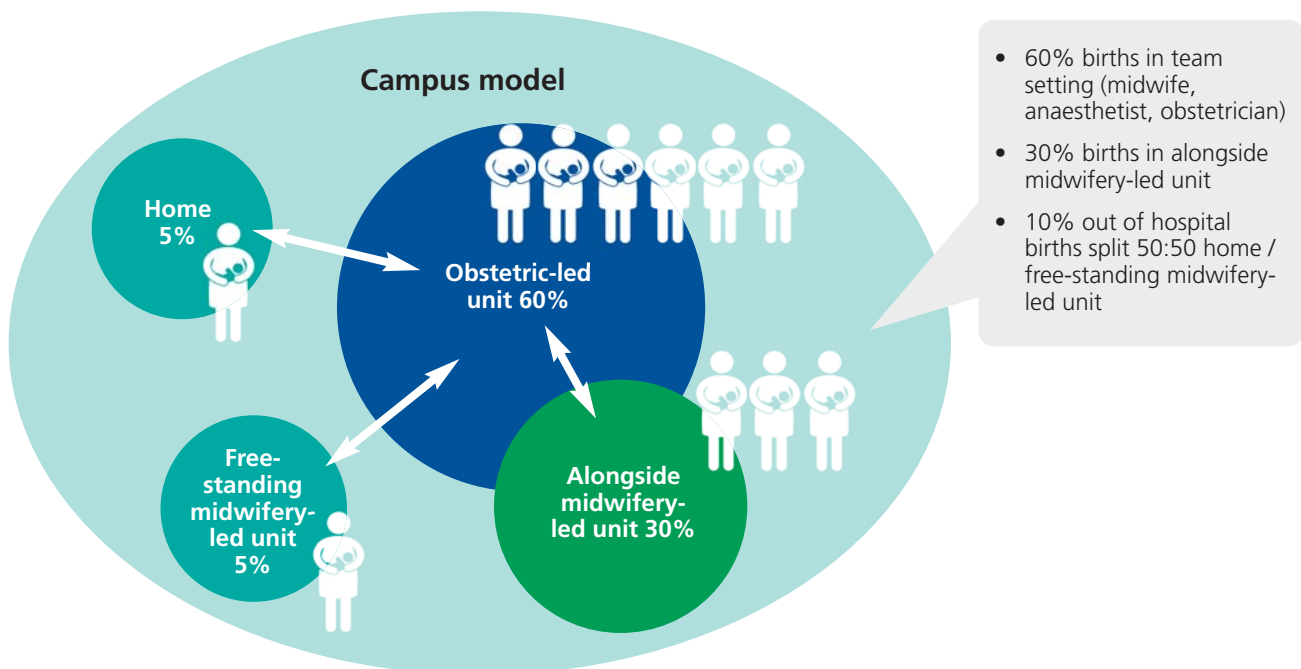
- If nothing is done, the capacity of north east London's maternity departments could run out from 2016–17; and by 2023–24 east London will need space for an extra 3,000–4,000 deliveries.
- Based on current use, north east London will need 12–15 more special care baby unit (SCBU) cots by 2023-24.
- The factors pushing up the birth rate (population increases, immigration and ethnic mix) are all likely to continue after 2023–24.

Managing capacity and demand is an ongoing challenge across the maternity network. This is particularly true for managing sufficient and consistent staffing levels across sites, as well as ensuring patient choice of where they give birth.

5 Midwifery-led deliveries should be the norm for births. This enables us to continue providing women with a choice of where they have their baby that is suitable to their level of risk.

The clinical working group has reviewed data from Homerton Hospital and Barts Health to identify differences in the rates of delivery in obstetric units alongside midwifery-led units (AMU) and in free-standing midwifery-led units (FMU). This shows that the system is not yet delivering the proportion of births across the current set-up as described in the *Health for NEL* recommendations shown below. For instance, 6.2% of deliveries at Barts Health were performed at home or at a free-standing midwifery-led unit, against a recommendation of 10%.

Health for NEL recommendation for a campus model in 2010



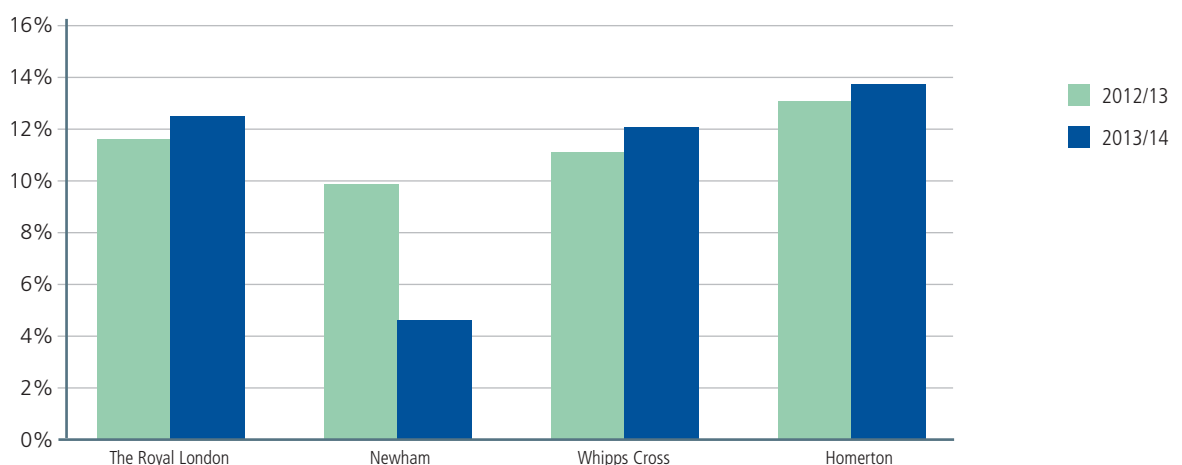
The clinical working group say too many deliveries are taking place in obstetric units and too few at free-standing units or at home. The group believes four main factors influence this:

- 1 **Women and the antenatal care providers are not always aware of all the birth options available to them.**
- 2 **Women may be referred to obstetric teams from antenatal care teams when they could have been suitably managed in a different setting.** For example, the group found that in one month on one site in Barts Health, 35% of referrals from midwife to obstetrician were potentially unnecessary and could have been managed safely and effectively in midwifery-led antenatal care³⁹.
- 3 **The induction-of-labour pathway currently leads to mothers giving birth in an obstetric-led unit.** We need to encourage women to have normal births and these women could potentially give birth in a midwifery-led environment.
- 4 **To increase midwifery-led births at the free-standing midwifery units, local difficulties need to be tackled.** The Barking and Barkantine Birth Centres are known to be underused. Attempts to promote them as safe units providing a good experience have had limited success, despite positive feedback from women who have given birth there. This may be because antenatal care professionals do not always know what they offer. With low use, the two centres are expensive to run and do not achieve the efficiencies that could enable the acute system to cope better with the extra births forecast.

6 New ways of working mean we could ensure more women have a natural birth and reduce the number who have interventions such as emergency caesarean-sections (c-sections).

The number of assisted births (those with interventions) ranges from 4.7% to 13.7%, which is likely to be influenced by protocols (rules on what to do and when) and variation in clinical decision making.

Assisted births percentages by hospital 2012/13 compared to 2013/14



³⁹ Barts Health NHS (2014): Antenatal booking audit

As the table below shows, c-section rates vary from 27.0% to 29.5%. Both Barts Health and Homerton Hospital are above the national and London average. The clinical working group said this is driven by differences in protocols, the amount of risk that was tolerated, and potential pressure on obstetric units. An audit of emergency c-sections at Whipps Cross Hospital found that in 29% of cases, a different management plan antenatally or during labour could have resulted in a different type of birth⁴⁰.

Variation in c-section rates across east London and the City

Trust	2012/13			2013/14		
	No of births	No of caesarean sections	% caesarean sections	Births	No of caesarean sections	% caesarean sections
Royal London	4,762	1,307	27.4%	4,744	1,291	27.2%
Newham	5,613	1,731	30.8%	6,491	1,769	27.3%
Whipps Cross	5,381	1,438	26.7%	4,431	1,254	28.3%
Homerton	4,344	1,238	28.5%	5,594	1,609	28.8%
Total all sites	20,100	5,714	28.4%	21,260	5,923	27.9%

The clinical working group reported a general lack of agreed protocols between providers and organisations. It said this could result in varied behaviours among clinicians, with some making more risk-averse intervention decisions. Recent reductions in c-sections at Newham Hospital have resulted from efforts between local partners to promote and work towards natural, midwifery-led deliveries.

However, the level of c-sections and other interventions must be seen in the context of the higher risk profile of women in east London, who tend to have lower-weight babies and, in certain populations, an increased prevalence of raised blood pressure and diabetes. The group agreed that some variation may not necessarily be a cause for concern. Illness and death rates have been proposed as an alternative quality measure.

7 It remains difficult to meet best-practice staffing levels across east London for obstetrics and midwifery.

The presence of consultants on labour wards varies from 70 to 80 hours a week across the four Barts Health and Homerton sites. Homerton Hospital plans to extend cover to 98 hours in October 2014. This compares to Royal College minimum standards of 96⁴¹ and London Quality Standards of 168 hours a week for units with more than 5,000 deliveries a year⁴². However, it is important to recognise that no trust in London currently meets the London Quality Standards.

40 Barts Health NHS (2014): Clinical audit of emergency and planned C-Sections Grades 1,2,3

41 Royal College of Obstetricians and Gynaecologists (2008): Standards for Maternity Care, report of a working party

42 London Health Programmes (2013): London Quality Standards – Quality and safety programme, Maternity Services

"I was discharged by a student nurse... and she also gave me all my files that the hospital should have kept. I even had to call a community nurse as no midwife or nurse checked me before or after my birth"

New mother in east London

None of the Barts Health units meets the London Quality Standard of 1:30 on the midwife-to-birth ratio. Barts Health sites range from 1:32 at both The Royal London Hospital and Newham Hospital to 1:33 at Whipps Cross Hospital. Neither The Royal London nor Newham sites are meeting 1:1 midwife care during labour across all birth settings. The recommended 1:15 ratio of supervisor of midwives to midwife is not met at any of the four east London sites.

There are various reasons for the shortfall in recommended staff ratios across midwifery nationally. The problem is complicated by existing vacancy rates, an ageing workforce and the ambiguities in calculating the capacity and capability of the midwifery workforce needed. However, The Royal London site has succeeded in recruiting midwives and has moved away from using agency staff in maternity services. Other sites have not yet achieved this.

8 We know we need to improve postnatal care. We want to standardise it across east London and improve the communication between hospitals, GPs and community services.

There is much variation in postnatal care across east London. This is because many service providers operate under different locally defined pathways and protocols.

Without consistent and visible pathways, hospital clinicians and patients find it difficult to access and navigate postnatal care outside the hospital, particularly for out-of-area births. As a result, we are not giving some women suitable referrals or receiving full and accurate information about care after their discharge.

Poor communication between hospitals, GPs and community services is restricting high-quality and seamless care. East London lacks enough IT facilities for clinicians to access and share medical records. Discharge information is often not detailed enough and sent by unreliable means. The discharge letter typically provides only limited information. It does not allow for the transfer of more detailed knowledge and advice that out-of-hospital clinicians could use to provide better-quality care. Discharge letters are typically in hard copy sent by post or handed to the parents. The lack of a system for sharing electronic care records between organisations increases the risk that we do not effectively communicate important or urgent discharge information.

.....

9 We need to do more to minimise the risk and effect of postnatal depression for new mothers throughout the maternity care pathway.

Currently in east London we have good services for new mothers with high-level mental health needs. But we don't respond effectively to those whose needs are low- to medium-level. We offer these women the Improving Access to Psychological Therapies (IAPT) service. As there are variable models of care across the boroughs, the service does not always provide a fast and integrated response. In addition, mental health and emotional support are not embedded within the antenatal care pathway.

10 We need to develop ways of measuring and benchmarking neonatal care in east London to ensure it is of high quality.

It is difficult to compare or benchmark the quality of neonatal care across east London. This reflects the national picture where the data is variable and inconsistent. We will need to develop an agreed set of indicators for all sites. We should then use this information to inform any clinical strategy we develop for neonatal care.

11 By standardising neonatal care pathways and protocols and transitional care, we will be able to ensure that babies can return home as soon as it is safe and that unwell babies continue to be cared for safely.

'Transitional care' means care that cannot be provided by the mother at home, such as intravenous antibiotics, which occurs outside a neonatal unit or in a ward setting and is not included in the specialised commissioning portfolio⁴³. The clinical working group has highlighted two important difficulties in caring for what are sometimes referred to as 'unwell, well babies' who need transitional care:

- 1 Lack of an agreed pathway for transitional neonatal care.
- 2 Lack of an agreed method for organisations to accurately record the level of demand for transitional care.

These problems have resulted in variations in practice, staffing (skills and numbers), joint working with other specialties, and protocols of care (e.g. use of antibiotics). The clinical working group says this creates delays to some discharges in obstetric and paediatric units, which in turn puts pressure on neonatal unit capacity.

The group reflected on the constant challenge in neonatal care of making sure babies are treated in the right care setting. This includes understanding staffing needs and neonatal capacity by identifying complications and risks early.

43 NHS England (2012-13): NICU and SC Service Specification

12 Capacity and capability in neonatal care and its workforce will need to increase to meet demand more effectively.

Neonatal care activity is increasing. Managing capacity and ensuring suitable staffing levels is getting more difficult.

Use of intensive-care cots across Barts Health and Homerton Hospital has risen by 11% in the last two years. High-dependency activity has risen by 1.5% and special care activity has fallen by 8%⁴⁴. The clinical working group acknowledged that neonatal demand is likely to increase with the forecast rise in births. Some 9% of all births will need some level of care in a neonatal unit. This suggests that both physical and workforce capacity and capability will need to cope with higher levels of demand in the future.

Calculating how many cots may be needed in future in east London is complex because services care for a wider population than just east London. But we estimate that 12 more special-care cots will be needed in east London units; this is a preliminary figure and more work is needed.

The group understands the current and future difficulties as regards the neonatal workforce. The optimal levels of perinatal medical staffing recommended by the British Association for Perinatal Medicine⁴⁵ are being met in east London. However, nursing staff ratios specific to each level of care are variable. So too are the ratios of neonatology-qualified to general-trained nursing staff compared to those recommended in the Commissioning High Quality Neonatal Care Toolkit⁴⁶. This is a national problem across all neonatal care providers, so it is not unique to London.

13 Through developing stronger consistent pathways and transfer protocols, we can provide more efficient and effective neonatal and paediatric services.

The handover of a child's care from neonatal to paediatric services is not as efficient and effective as it should be. Our discharge information does not share the full depth of neonatal clinical knowledge with GP and community services. Without joined-up IT systems, services outside hospital have difficulty accessing hospital records. Clinical working group members said lack of good discharge information meant some babies had been admitted to paediatric care only a few days after going home from a neonatal unit.

14 There is interdependency between how neonatal demand is managed in east London and the neonatal transfer service. So any recommendations about future types of neonatal care must take into account the effect on neonatal transport.

The clinical working group thinks there are inconsistencies in neonatal transfers. Too often there have been long waits (up to six hours) in east London. New specialist ambulances have provided higher-quality facilities. But the group felt some babies are waiting too long to reach the most suitable care facilities. And the group thinks that having to provide a nurse for the transfer is negatively affecting the staffing and care at the sending trust.

44 London Perinatal Network (2012): Annual Report 2011/12

45 British Association for Perinatal Medicine (BAPM) (2014): Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing.

46 Department of Health (2009): Toolkit for High Quality Neonatal Services

Emerging priorities and models of care

Based on the clinical working group's analysis, we set out the main emerging priorities and models of care below:

We need to overcome the barriers that prevent us delivering more care closer to home

Working closely with the primary care *Transforming Services Together* workstream (see section 10 for more information), we need to map the current model of antenatal care in more detail to see where it is being provided and by whom. By better integrating and strengthening antenatal care, we believe we will:

- empower more women to make the right choices about their care by ensuring they are better informed of what care is available and how they can access it
- identify risks earlier, thereby improving access to suitable treatment and further assessment when needed.

We recognise the essential role of effective antenatal care in managing demand along the maternity pathway. We also believe that women who access antenatal care early are more likely to choose a place where they wish to give birth that is most suited to their level of risk. We believe this will result in:

- reduced demand on the acute midwife workforce
- developing a named midwife model of care, with the associated improvements in outcomes and patient experience
- better management of demand in caring for healthy women and their babies during childbirth.

We need to increase opportunities for women to have a normal delivery with the best possible outcomes for mothers, their babies and their families

Increasing the opportunities for women to have a 'normal delivery' will reduce risks of complications for both the mother and baby. It will also improve their experience of birth and help manage demand by ensuring we make the best use of our workforce and physical capacity.

To improve the likelihood of women having a normal delivery, maternity service providers should prioritise the following actions:

- Streamline the induction of labour (IOL) pathways and protocols according to best practice. This will decrease the time women wait from admission to induction of labour. It will also reduce the risk of them needing an emergency c-section
- Implement a new training programme for obstetric registrars to increase their confidence and competence in trialling births using medical instruments when safe to do so, before deciding to perform c-sections

- Identify and reduce the existing barriers to increasing the use of midwifery-led units and development of home-birth midwifery teams, as recommended in *Health for NEL*
- Ensure the service improvements listed above are closely linked to the proposals for improving antenatal care. This will increase the likelihood that all women will have a named midwife to promote suitable choices and better outcomes.

We need to support women more effectively through postnatal services

To achieve this, we need to do a more detailed review of how we currently provide postnatal care and the outcomes we achieve. We also need to set out proposals for giving more detailed information to GPs and acute maternity services about the services and care available for women and their families in east London and how they access it. We need to work with local authorities and voluntary organisations to achieve this.

We need to plan for the future recruitment, education, training and professional development needs of our workforce

More midwives and consultants are needed. However, it is hard to know how many, where they will be working, and what skills and competencies they will need. Therefore, we have to do a detailed review of workforce capacity and capability. Then we can understand where gaps exist so we can form sustainable plans to tackle these difficulties.

We need to ensure the system is prepared for the forecast additional births

We need to take forward work to plan for the forecast additional births in north east London. In particular, shifting towards more normalised births should help to take the pressure off obstetric units by:

- increasing the numbers of home births
- increasing births in midwifery-led units where some units have capacity
- reducing the number of inductions overall and increasing the number of inductions on an outpatient basis.

These proposed solutions will help with capacity only in the short to medium term. They do not solve the longer-term workforce constraints. Providers and commissioners will therefore need to:

- conduct detailed capacity and demand modelling that is regularly revisited, to understand which sites will come under most pressure
- plan capital investment to increase capacity where it is limited

- consider further changes to our referral pathways to match forecast deliveries to each hospital's safe capacity
- do a workforce needs assessment to plan for future recruitment
- ensure providers have robust plans for recruiting and retaining staff that take account of future expected growth.

We need to ensure adequate support for women who have mild to moderate levels of mental health need

We need to develop an effective way of identifying women with mild to moderate levels of mental health need. This may include the following actions:

- developing a fast-track Improving Access to Psychological Therapies (IAPT) service
- applying a 'named midwife' model to improve integration between midwifery services
- working with local authorities to understand and tackle concerns we heard during engagement with staff about future changes to health-visiting services – particularly that there will be less focus on emotional well-being, given the difficulties they face in meeting their safeguarding responsibilities
- giving information to all service providers (including the voluntary sector) on support available, including for out-of-area women.

We need to ensure we apply robust methods to measure the quality of neonatal care, patient outcomes and demand for transitional care

To help us measure progress, we need to create a baseline for the current quality of neonatal care. Plans to increase the number of middle-grade neonatology and paediatric registrars on call could solve the problem of needing greater access to medical staff cover. However, we need to review this as a potentially viable and affordable option across all sites.

We also need local agreement on a standardised approach to measuring demand for transitional care. The effect of the birth forecast on neonatology needs must be considered as part of wider analysis of capacity and demand.

7.5 Services for children and young people

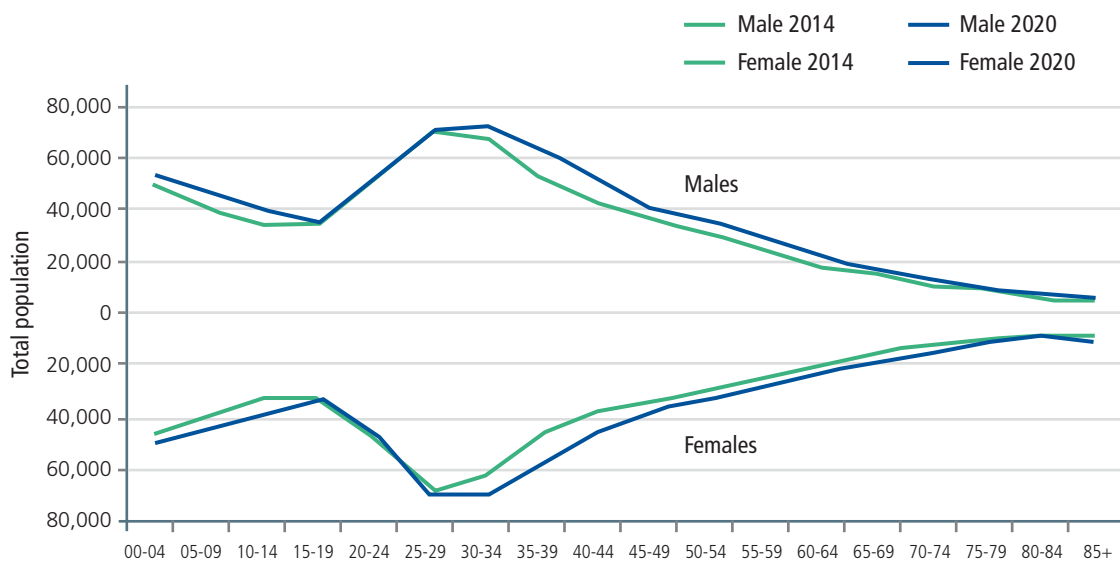
This section summarises the findings of the Children and Young People Clinical Working Group, giving an overview of the context that local services are operating within, the *Case for Change* and emerging priorities and models of care for the future

Context

East London has a higher-than-average proportion of children and young adults. About 217,000 children aged 0–19, account for 27% of the population in Newham, Tower Hamlets, Redbridge and Waltham Forest. The number of children and young people in the four boroughs will continue to rise rapidly with about 8% growth expected over the next five years (representing 16,000 more children and young people)⁴⁷. Forecast growth is particularly high in the 10–14 age group.

The population of children and young people is culturally diverse, with between 80.2% (Waltham Forest) and 92.8% (Newham) of school children from a minority ethnic group and higher-than-average rates of non-English speakers⁴⁸. There is a high level of population movement – as high as 30% annually in Newham⁴⁹.

Combined Newham, Redbridge, Tower Hamlets and Waltham Forest population by age band and sex 2014-2020



47 Office for National Statistics (ONS) (2012) and Greater London Authority

48 Public Health England (March 2014): Child Health Profiles

49 Newham CCG (2013): Primary healthcare strategy 2013-18

Importance of prevention and screening in the local population

Deprivation is a significant factor in east London, with high child poverty and poor nutrition rates contributing to the high demand for health services. The rate of child poverty and family homelessness in the area is higher than the England average with between 23% (Redbridge) and 43.6% (Tower Hamlets) of children under 16 years living in poverty (England average is 20.6%⁵⁰).

Locally there is a need for well-developed prevention, public-health and screening services. The levels of childhood obesity are above the England average in all boroughs. This contributes to a predicted earlier onset of health complications related to long-term conditions, potentially increasing the demand for health services in the future.

Using the 2012 public health population estimates, we predict that just over 24,000 local children and adolescents (5–16 years) will have a mental health disorder. The number of emergency admissions for children and young people who have self-harmed ranges from 0.66 per 1,000 (Redbridge) to 1.21 per 1,000 (City & Hackney).

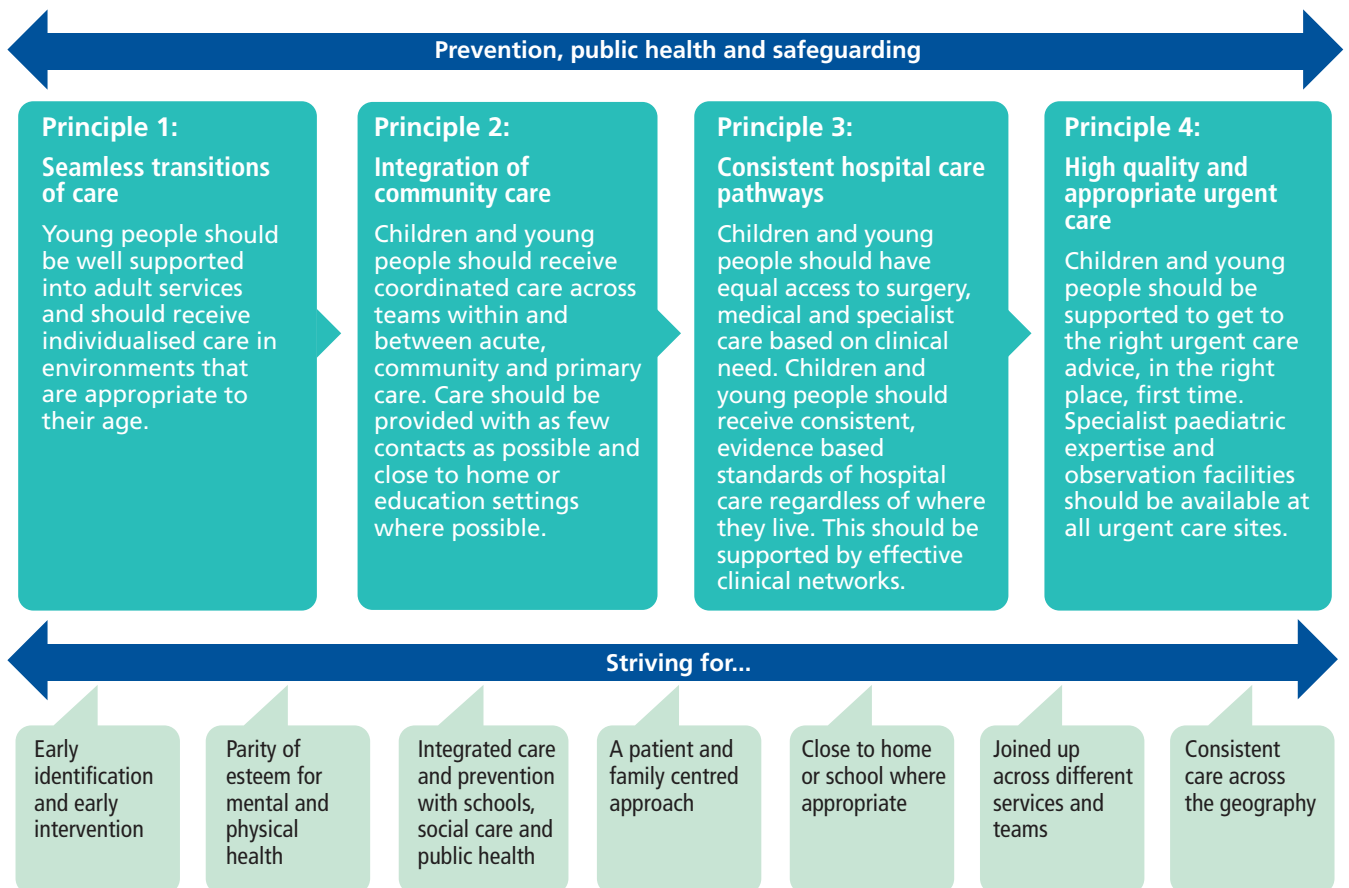
Paediatric services are provided at all four of the main acute hospital sites. The Royal London Hospital provides both complex and less-complex paediatric services, while Homerton, Newham and Whipps Cross hospitals provide less-complex paediatric services. All sites provide paediatric emergency services.

Children and young people: the case for change

- 1 We can better support young people as they move to adult services, to ensure they don't fall through the gaps.
- 2 More children should be cared for closer to home through stronger primary care support.
- 3 Clearer pathways for children would reduce the burden on general paediatrics and mean that patients see the right clinician the first time.
- 4 There is the opportunity to provide more joined-up care for children and young people with complex needs.
- 5 The development of consistent standardised pathways across east London in all clinical settings would provide more equitable, consistent and higher-quality services for children and young people.
- 6 We need to develop clear, easy-to-navigate, consistent pathways that enable children and young people to access the right urgent-care support.

⁵⁰ Public Health England (March 2014): Child Health Profiles

We have made our case for change by comparing current services with principles that the Children and Young People's Clinical Working Group have set out for good care:



1 We can better support young people as they move to adult services, to ensure they don't fall through the gaps.

Preparation for adult services: The clinical working group believe that children and young people are not being adequately prepared for their transition to adult services. Too many young people struggle to effectively function in adult systems, which generally expect them to take more control of their own health (self-care). There are insufficient safety mechanisms to ensure that young people moving to adult services do not fall between the gaps in services. This is a particular risk for young people with long-term conditions.

Consistent and simple transitions: Varying cut-off and acceptance ages for different services and providers can result in staggered and over-complex transitions along several care pathways for children and young people with complex needs. Young people with mental health and special educational needs often do not meet the threshold for acceptance to adult services, so they can immediately drop out of a care system at a vulnerable age.

"There is a need to focus on children's mental health services and change them to suit the changing society"

Attendee at Healthwatch event at Whipps Cross Hospital

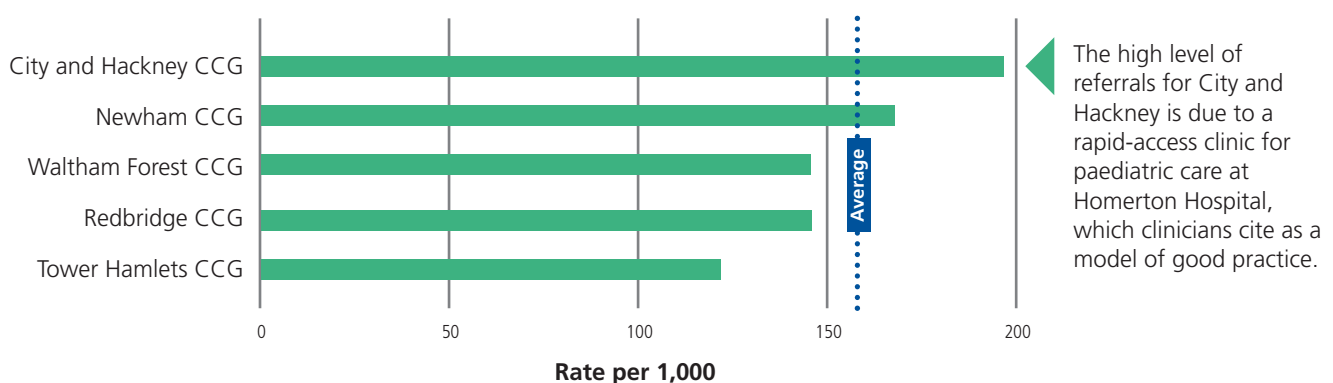
Neonatal transitions to paediatric services: Discharge and handover arrangements are often too simplified in a single letter to a GP, with an associated loss of valuable knowledge and expertise. Existing IT systems do not support easy access to medical records across providers. There is a risk that babies with complex needs who are discharged from neonatal units and later attend or are admitted to paediatric services, will see staff who have no prior knowledge of their needs.

2 More children should be cared for closer to home through stronger primary care support.

Access to specialist advice and guidance: The clinical working group acknowledges there is significant variation in the skills, confidence and formal training of primary care clinicians in paediatric care. The group discussed GPs' variable levels of confidence in their paediatric skills, and the lack of a current curriculum for primary care education. With increased access to specialist advice and guidance, a greater proportion of children could be treated in primary care.

Improving the suitability of referrals: There were 117,000 outpatient appointments across the three Barts Health sites and Homerton Hospital from October 2012 to September 2013. There is significant variation (62.5%) in the rate of first outpatient attendances (numbers of referrals) for 0–18 year olds, even if figures for City and Hackney are discounted (seen in graph below).

First attendances per 1,000, all providers, 0-18 year olds, October 2012 – September 2013

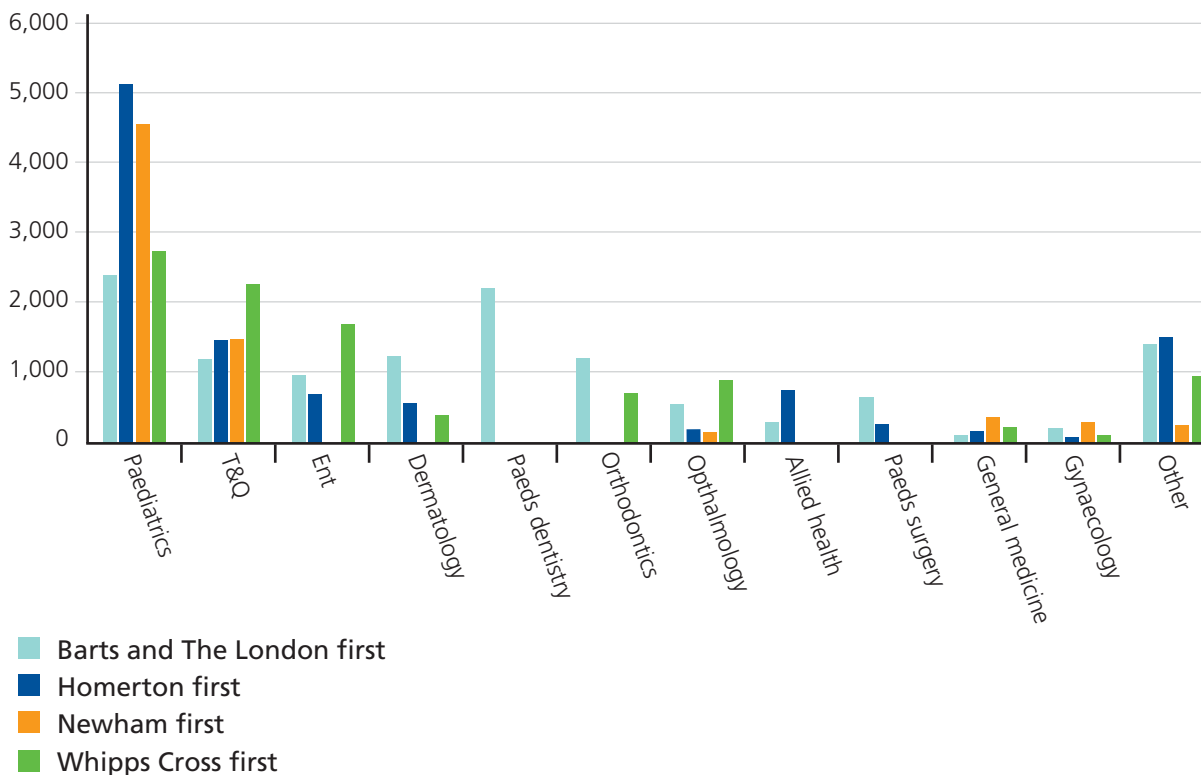


3 Clearer pathways for children would reduce the burden on general paediatrics and mean that patients see the right clinician the first time.

The graph below shows that over a third of attendances take place in paediatric clinics, with the greatest volume at Homerton and Newham hospitals – indicating the high level of demand at these departments. On referrals, the main issues that the clinical working group has considered are:

- There appears to be significant variation in the referral pathways and processes for each of the hospital sites across east London. There are also variations in referral criteria, thresholds for acceptance and triage at the different sites. These may contribute to the variation and create difficulties for the referring clinician and patient in navigating the pathway.
- Best available data suggests a high proportion of consultant-to-consultant referrals, particularly at Newham Hospital (57% of referrals). This could mean patients are being redirected unnecessarily after first assessment. So there could be greater efficiency in how paediatric referrals operate, enabling children to see the right clinician the first time.

First attendances by specialty⁵¹, TSCL CCGs 0-18 year olds, October 2012 – September 2013



51 TF.code

4 There is the opportunity to provide more joined-up care for children and young people with complex needs.

Children and young people with complex needs often get multiple appointments with a broad range of teams. There is often little coordination, resulting in a poor patient experience.

Across the area, the clinical working group saw variation and inconsistency in care pathways, influenced by local procedures and clinical decision-making. Clinicians often struggle to provide a coordinated service, in large part because they simply do not know about the different services available and the acceptance criteria required.

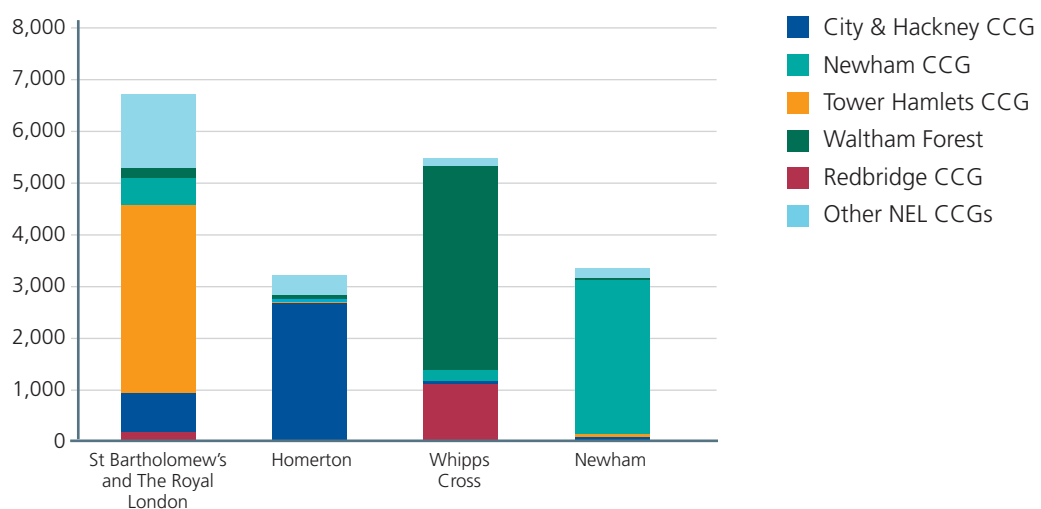
5 The development of consistent standardised pathways across east London in all clinical settings would provide more equitable, consistent and higher-quality services for children and young people.

Equitable access: The clinical working group has observed that children and young people lack equal access to hospital care in east London. *Health for NEL* recommended setting up clinical networks across hospital sites. The group supports this recommendation and knows the important role of clinical networks. However, we have so far failed to establish robust, operationally viable networks with a formal governance structure covering the complex array of children and young people's care including, paediatric specialist care, medical care, elective surgery and emergency surgery.

Right care, right place: There is significant variation in the admission rates of children and young people. There also appears to be variation in onward admission to specialist services, with 19% of City and Hackney children, 15% of Newham children and only 3.5% of Waltham Forest children admitted to The Royal London Hospital⁵² (see graph below).

This highlights the variation in urgent-care and inpatient models and pathways at each site and suggests variation in the experience and quality of care across east London.

Non-elective spells by CCG and site



52 Secondary Uses Service (SUS) data

7 Do all patients benefit from a consistently world-class service?

“Too many referrals and too much being passed around. My daughter’s stoma bag had come loose. I went to the GP, who sent me to my local hospital, who sent me to the Royal London Hospital – where the care was brilliant”

Mother of 7-year-old daughter with bowel condition. (Romford)

“My daughter had an X-ray in adult radiography department in one hospital and got very upset. She had second X-ray in paediatric radiography at the Royal London. There was a TV screen above her and she was so much calmer”

Mother of 7-year-old daughter with bowel condition. (Romford)

Consistent care and dedicated facilities: The Royal College of Paediatrics and Child Health (RCPCH) states that, wherever possible, children should be treated by paediatric specialists in separate, dedicated or child-focused facilities⁵³. To understand our current position and local compliance against other standards, including those set out in *Health for NEL* and the London Quality Standards, Barts Health and Homerton Hospital completed self-assessment audits. These showed that paediatric surgical and anaesthetic expertise is not provided consistently across all sites. In some cases it fails to meet the required standards⁵⁴, potentially resulting in variations in care quality. Whipps Cross Hospital is the only site that meets the standard for all emergency admissions being seen and assessed by the responsible consultant within 12 hours of admission.

6 We need to develop clear, easy-to-navigate, consistent pathways that enable children and young people to access the right urgent-care support.

Right place first time: Too many children and young people attend A&E when they could be safely cared for at, or closer to, home. Attendances for children and young people at Barts Health and Homerton Hospital’s A&E sites account for 28% of the total against a national average of 23%⁵⁵. Between October 2012 and September 2013, 73,555 attendances across all sites resulted in no diagnosis or treatment, showing that many children could have been cared for closer to home⁵⁶.

A high-level mapping exercise of paediatric urgent-care services available in east London revealed inconsistent provision in the range of services provided and their hours of operation. No services offered across east London provide clear and consistent urgent-care pathways with a single point of access, available 24/7, enabling access to the right care, quickly and easily. This is probably influencing the high levels of A&E activity.

⁵³ Royal College of Paediatric and Child Health (RCPCH) (2011): Facing the future: A review of paediatric services

⁵⁴ Barts Health and Homerton (2014): self-assessment audit

⁵⁵ and ⁵⁶ SUS data

Consistent standards of care: The A&E and urgent-care centre services at Barts Health sites and Homerton Hospital use different models from each other. There are different observation and assessment facilities across sites. Unplanned admission rates across clinical commissioning groups (CCGs) and sites vary from 47 per 1,000 population to 64 per 1,000 in different CCG populations. All sites had strengths and weaknesses that could provide opportunities to share good practice. In addition, too many children and young people are being admitted to hospital, particularly for a day or less, when many could instead be treated in a different setting.

Staffing: A large proportion of A&E attendances are from 0–19 year olds across all sites; for example, they account for 28% of total A&E attendances at The Royal London Hospital. Yet currently A&E paediatric consultant staffing is not enough to give consistent high-quality care at all sites, 24 hours a day, seven days a week. As shown by the London Quality Standards self-assessment, there are too few paediatric consultants to cover A&E. So the paediatric acute team has to support A&E, diverting clinical care away from inpatients.

Emerging priorities and models of care

Based on the clinical working group's analysis, we set out the main emerging priorities and models of care below.

Young people should be well supported into adult services and should receive individualised care in environments that are suited to their age.

We need to develop simple and consistent but flexible transitions for young people, which respond to their individual needs rather than the limits of service provision. We need to improve communication between professionals and organisations to ensure patients' needs are not missed.

Coordination of care needs to be improved through the use of lead professionals to help young people navigate their way into adulthood. A possible solution is to develop a directory of services that would help young people, parents, carers and professionals to navigate care pathways and services.

"NHS staff have a positive attitude to children. The attitude to young people/teenagers is often less positive"

Young Adviser, London Borough of Waltham Forest (attendees were aged 15–21)

Children and young people should receive coordinated care across teams in (and between) acute, community and primary care. Care should be provided with as few contacts as possible and close to home or education settings where suitable.

We need to explore alternative models of providing service delivery that will allow the integration of services across agencies and sectors. One way would be to improve existing integrated care programmes to include children and young people. We should again consider using a lead professional to coordinate and navigate care for children and young people with complex needs and mental health problems. The clinical working group found evidence that agreed with the London Health Commission's findings that services are hard to access, poorly coordinated between primary care and community, secondary and tertiary care, and that there are inadequate links between them⁵⁷. Given this, work to integrate and better coordinate services should now be taken forward.

We need to ensure that we maximise the potential for universal services (services provided to all children, young people and their families from health, education and other community services) so that we can identify problems early and take action to achieve better outcomes. We need to help primary care staff manage patients within primary care, when appropriate to do so, by developing initiatives that build on good practice. This will:

- improve the suitability of referrals, and
- ensure staff have suitable access to specialist advice and guidance.

Children and young people should have equal access to surgery, medical and specialist care based on clinical need. Children and young people should receive consistent, evidence-based hospital care regardless of where they live, supported by effective clinical networks.

We need to take forward work to develop effective and operationally viable clinical networks to share best practice, develop shared protocols and actively manage capacity, resources and demand across east London. This should include the development of standardised, evidence-based protocols to support consistent high-quality care. We need standardised pathways with clear policies and services that are staffed by a sufficient workforce, suitably trained in paediatric skills.

Children and young people should be supported to get to the right urgent-care advice in the right place, first time. Specialist paediatric expertise and observation facilities should be available at all urgent-care sites.

To help achieve this, we will need to further map the full range of facilities that provide paediatric-focused urgent care, including their location, hours of operation and the level of complexity of the conditions they treat. This will help us develop other models of urgent care with consistent entry points to reduce confusion about the services available. In particular we should focus on investigating improved walk-in care for children as part of our unplanned care service.

We need to further develop consistent primary care extended-hours schemes. We need to develop an urgent-care directory of services that clearly sets out what is available to patients in the local area and how to access services. We also need to assess the number and nature of the workforce. This work should be led by the urgent-care workstream in the *Transforming Services Together* programme (see section 10 for more information).

⁵⁷ London Health Commission (2014): *Better Health for London* p40

7.6 Services for people with long-term conditions

This section summarises the findings of the Long-Term Conditions Clinical Working Group, giving an overview of the context that local services are operating in, the case for change and emerging priorities and models of care for the future.

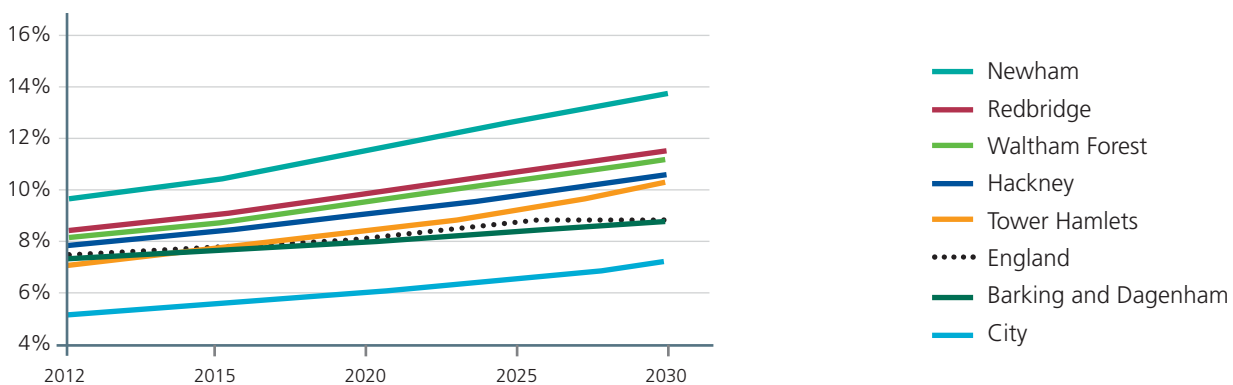
Context

Locally, there is a low prevalence of long-term conditions like cardiovascular disease, kidney disease and stroke. This probably reflects the younger age profile of east London's population. However, conditions such as diabetes are far more prevalent⁵⁸. This is likely to reflect the high proportion of people with a south Asian background.

The growth in the prevalence of many long-term conditions in east London is lower than London and England's average growth rates⁵⁹, but the prevalence of some conditions is expected to rise.

For example, the prevalence of diabetes in north east London is growing faster than the national average (see graph below). In Newham the prevalence of diabetes will be 57% higher than the national average by 2030⁶⁰.

Diabetes prevalence: estimated total diagnosed and undiagnosed prevalence in adults 2012 to 2030



⁵⁸ Public Health Observatories (2010): prevalence modelled from factors in the population

⁵⁹ Network of Public Health Observatories (2012)

⁶⁰ National Diabetes Information Service: <http://www.yhpho.org.uk/default.aspx?RID=154049>

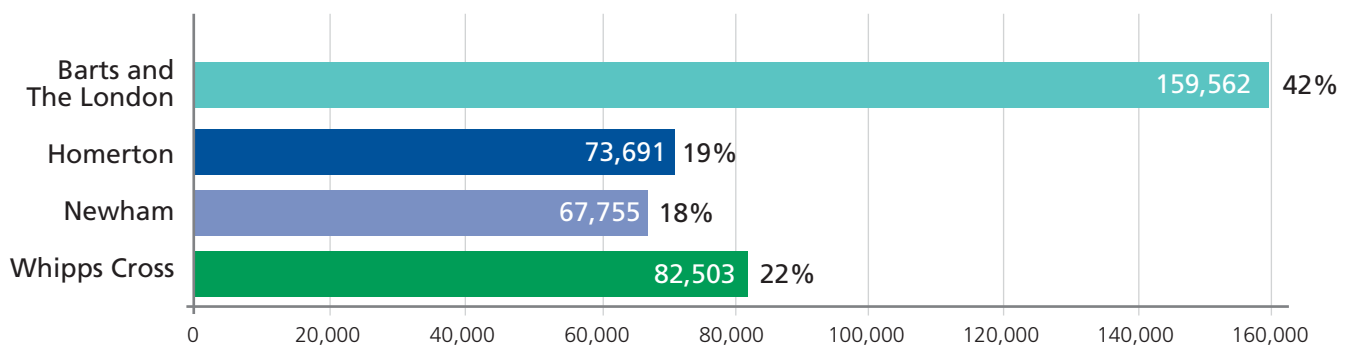
People with long-term conditions tend to be heavy users of healthcare resources⁶¹. For example, nationally, people with long-term conditions account for half of all GP appointments and half of all inpatient bed days. In east London, 20% of the population accounts for 80% of acute care costs⁶². Nationally, 30% of the population accounts for 70% of acute care costs⁶³.

Outpatient appointments

In 2012/13 there were 385,111 outpatient attendances for people with long-term conditions across Barts Health and Homerton sites⁶⁴. Over 40% of these were at St. Bartholomew's or The Royal London, with a fairly even split between Whipps Cross (22%), Homerton (19%) and Newham (18%) hospitals. A breakdown by specialty shows that the top five high-volume specialties are respiratory medicine, gastroenterology, cardiology, rheumatology and dermatology.

The biggest reason for outpatient appointments not taking place are 'cancellation by the hospital' at The Royal London and Whipps Cross, and 'patient did not attend' at Newham and Homerton.

385,111 outpatient attendances by people with long-term conditions, by site (October 2012 to September 2013)



Hospitalisations of people with long-term conditions

Benchmarking shows a large variation in hospitalisation for people with 'chronic ambulatory care sensitive conditions'⁶⁵. These are conditions where better management of their condition or earlier treatment could have meant the patient didn't need to be admitted to hospital – for example, a diabetic patient taking steps to avoid low blood sugar levels and, if needed, getting early advice or treatment.

61 General Lifestyle Survey (2009)

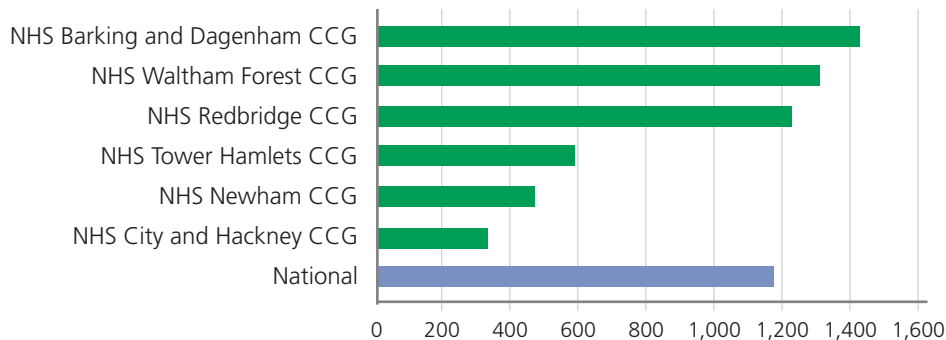
62 McKinsey (2012): Developing the case for change in establishing an Integrated Care System across WELC

63 Department of Health (2012): Long-term conditions compendium of information

64 SUS data has been extracted according to a set of specialties for patients aged over 20 from October 2012 to September 2013

65 People with long-term conditions such as asthma and diabetes, who could be better managed in the community

Unplanned hospitalisations per 100,000 population for chronic ambulatory care sensitive conditions (2012/13)



City and Hackney has the lowest number of unplanned hospitalisations per head of population in London, with 325 per 100,000 compared to a national average of 1,182. Barking and Dagenham has the highest rate of admissions for these conditions in London (1,406 per 100,000 population), which is higher than the England average.

Long-term conditions also lead to a lot of planned care. There were 56,572 planned spells⁶⁶ for patients with long-term conditions in 2012/13. Of these, 57% took place at the St. Bartholomew's or The Royal London hospitals, 19% took place at Whipps Cross, 15% at the Homerton and 9% at Newham hospitals.

Public health interventions, social care support and joint working

The wider causes of poor health in east London, such as level of deprivation, affect the prevalence of long-term conditions. Benchmarking of local authority spending on public health in east London boroughs shows a significant variation from £36 per head of population in Redbridge to £117 per head in Tower Hamlets; the London average is £74 per head. Spending on adult social care services also varies significantly from £203 per head in Newham to £317 per head in Tower Hamlets; the London average is £299 per head⁶⁷.

Over the last year the WELC Integrated Care Collaborative⁶⁸ has been working to develop a joint integrated care programme across Newham, Tower Hamlets and Waltham Forest. This programme aims to bring stakeholders together to provide more patient-centred services for physical health, mental health and social care. The long-term conditions clinical working group and WELC Integrated Care Collaborative co-operated on their vision for care.

Carers' important role

The clinical working group recognised and valued the vital role of carers in providing care and support to people with a long-term condition. When we define what good care looks like, we apply the principle that care needs to be tailored to individual needs. This includes valuing and recognising the needs of carers.

⁶⁶ Elective spells for North and East London CCGs, i.e. Barking and Dagenham, Barnet, Camden, City and Hackney, Enfield, Haringey, Havering, Islington, Newham, Redbridge, Tower Hamlets, and Waltham Forest CCGs that took place at Barts Health NHS Trust and Homerton University Hospital NHS Trust

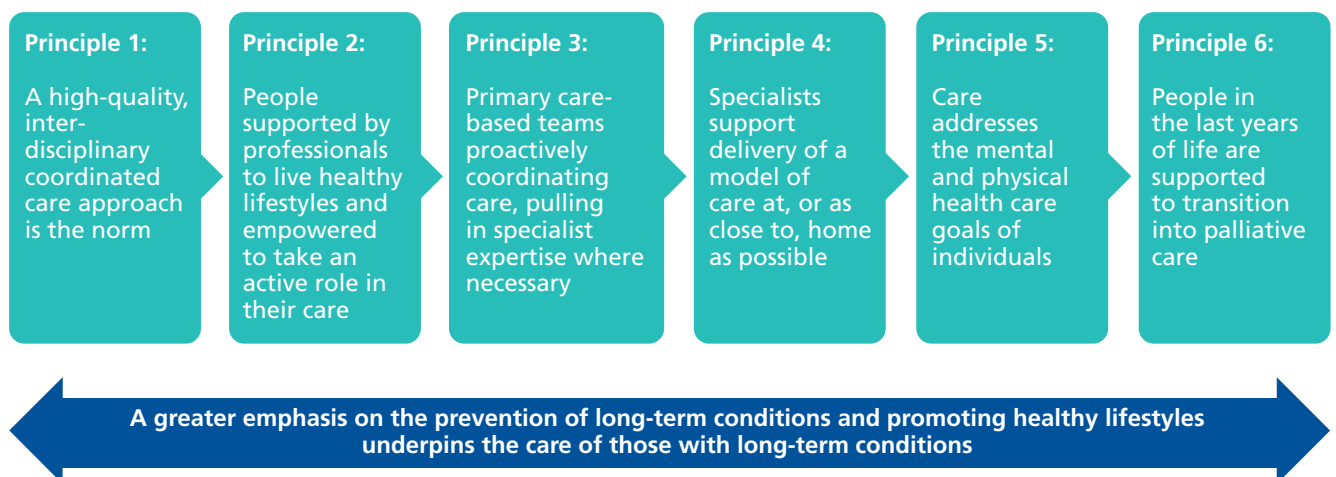
⁶⁷ YHPHO – Spend and outcome tool (SPOT): local authorities (2014) <http://www.yhpho.org.uk/resource/view.aspx?RID=203757>. [Accessed 2nd September 2014].

⁶⁸ Newham, Tower Hamlets and Waltham Forest CCGs, the respective local councils, Barts Health, ELFT, NELFT, UCLP

Services for people with long-term conditions: the case for change

- 1 We do not systematically provide high-quality care planning. Clinicians have told us that in many cases the extent to which the system supports patients to better manage their health is piecemeal and tokenistic. A 'whole-system' approach is needed to support people to manage their own health and lead fuller lives.
- 2 With support and resources, primary care teams could take the lead in coordinating the care of patients with long-term conditions and re-establish the GP's role as 'expert generalist'.
- 3 New models of outpatient care could provide more effective, sustainable care to patients when they need it.
- 4 The NHS needs to work more closely with partners to help with discharge from hospitals and prevent avoidable readmissions.
- 5 To truly improve the care people receive, we must address both their mental and physical needs.
- 6 Too few people are supported to die in their place of preference at the end of their lives. We must develop better ways of meeting each person's individual needs.

The clinical working group developed the case for change by comparing current services with principles that the group set out for good care:





The case for change is as follows:

1 We do not systematically provide high-quality care planning. Clinicians have told us that in many cases the extent to which the system supports patients to better manage their health is piecemeal and tokenistic. A 'whole-system' approach is needed to support people to manage their own health and lead fuller lives.

Percentage of people who feel supported to manage their condition (GP survey, 2014)

CCG		England average 68.5%
City & Hackney	58.9%	
Tower Hamlets	58.5%	
Redbridge	58.2%	
Barking & Dagenham	57.8%	
Waltham Forest	57.2%	
Newham	53.7%	

Nationally, only a third of people with a long-term condition say they have a care plan. A recent Diabetes UK study found that for many, NHS support in creating a care plan felt like a 'tick box' exercise⁶⁹. Locally, the picture is even worse, with 91% of patients saying they did not have a written care plan⁷⁰.

Care planning is often completed in organisational silos, a situation worsened by the increasingly fragmented health and social care system. There is no agreed, standardised approach across services for developing or managing care plans jointly. Systems and processes are not set up to support collaborative care planning or the electronic sharing of care records. We do not fully assess and manage the mental health needs of patients with long-term conditions as part of care planning.

We operate an over-medicalised and paternalistic model that seeks to 'fix' patients rather than empower them to make choices about their health and healthcare. Primary care reimbursement programmes, such as the Quality and Outcomes Framework (QOF) do not seem to encourage interventions that support patients changing their behaviour, as this is more difficult to measure and therefore reward.

The QOF, in particular, follows a condition-specific model that does not cover all conditions and focuses on task-oriented activities rather than promoting engagement and empowerment. It is widely agreed that clinicians across the system lack the time to effectively support self-management.

Equally there is often low uptake of education courses nationally⁷¹ by patients and we need to provide support that suits their cultural background.

⁶⁹ Diabetes UK (2014): Lack of care planning failing people with diabetes. http://www.diabetes.org.uk/About_us/News/Lack-of-care-planning-is-failing-people-with-diabetes/

⁷⁰ GP Survey (2013): <http://practicetool.gp-patient.co.uk/Practice>

⁷¹ National Diabetes audit



2 With support and resources, primary care teams could take the lead in coordinating the care of patients with long-term conditions and re-establish the GP's role as 'expert generalist'.

Primary care teams are either not set up to act as care coordinators for patients with long-term conditions, or lack the support they would need from the wider health and social care system to perform that role. There needs to be a renewed focus on the GP as 'expert generalist' who is supported by the wider healthcare system to integrate services for the patient.

Capacity, training and education need to be improved to enable these things to happen. Primary care access and quality scores show there is an opportunity to improve access to GPs as all the boroughs in east London are below the national average⁷².

Social care arrangements to support GPs in a care coordination role vary by borough. The worsening of a patient's condition to the point when they need admission to a hospital can be as much a failure of social support systems as the healthcare system. Health and social care professionals need to work together to stop unnecessary hospital admissions. Feedback from local mental health clinicians shows that parity of mental and physical health is not being achieved.

**"A 10-minute consultation
is not enough time to make
life-changing decisions"**
*Attendee at long-term conditions
focus group*

**"Patients with complex
long-term conditions see lots of
consultants – couldn't patients
meet with all the different
consultants at once?"**
*Attendee at long-term conditions
focus group*

⁷² <https://www.primarycare.nhs.uk> aggregated January to March and July to September 2013.

3 New models of outpatient care could provide more effective, sustainable care to patients when they need it.

The Long-Term Conditions Clinical Working Group believes that the current model of outpatient care is outdated. The system is wedded to a 20th-century model of service, which is worsened by contractual arrangements and custom and practice. In particular, the group believes that three-monthly routine follow-up interactions that last little more than 10 minutes add limited value and that with the right support primary care staff could suitably manage some of these patients.

4 The NHS needs to work more closely with partners to help with discharge from hospitals and prevent avoidable readmissions.

Systems should be in place to facilitate discharge and prevent avoidable readmissions. Homerton Hospital has more delayed transfers of care based on social care reasons (the highest proportion relate to awaiting a care package), while Barts Health sites have more delays based on health reasons (completion of assessment or awaiting further NHS non-acute care)⁷³. The accessibility of community and social care services significantly affects length of stay and the ability to discharge patients suitably. The current high levels of unplanned care for people with long-term conditions are an important sign of a failure in the planned care system.

5 To truly improve the care people receive, we must address both their mental and physical needs.

There is a strong link between physical long-term conditions and psychological distress/disorder. Mental health problems are much more common in those with physical illness. Compared with the general population, people with diabetes, high blood pressure and coronary artery disease have double the rate of mental health problems⁷⁴. People with two or more long-term conditions are seven times more likely to have depression⁷⁵. The case for change in achieving parity of esteem between physical and mental health care is important. We discuss it further in the mental health section of this document (see page 57).

6 Too few people are supported to die in their place of preference at the end of their lives. We must develop better ways of meeting each person's individual needs.

The Department of Health reports that 75% of people say they would prefer to die at home but nationally, only 21% do. Locally, only City and Hackney exceeds national levels (22.5%)⁷⁶. Waltham Forest has the lowest proportion of people dying at home (17%) and the highest proportion of people dying in hospital (67%). None of the clinical commissioning groups in east London achieves a rate better than the national average for patients dying in hospital (50%). Care should be suited to each person's needs, including supporting people to die with dignity.

73 NEL CSU 2013/14 Performance Data

74 Department of Health (2012): Long-term conditions compendium of information

75 NICE (2009): Depression in adults with a chronic physical health problem: treatment and management <http://www.nice.org.uk/nicemedia/pdf/CG91FullGuideline.pdf>

76 http://www.endoflifecare-intelligence.org.uk/profiles/CCGs/Place_of_Death/atlas.html

Emerging priorities and models of care

Based on the clinical working group's work, the emerging priorities and models of care are as follows:

Every patient with a long-term condition should have a current and shared care plan

Care planning should be the cornerstone of care for people with long-term conditions. To ensure this is so, there needs to be a complete change in how care planning is done. Care planning needs to effectively take into account both the physical and mental care needs of patients. Ways of working, as well as IT systems, need to support the sharing and updating of care plans across organisations to enable care plans to be 'live' tools. The WELC Integrated Care Collaborative is working to develop care plans and the care-planning process further and will take forward this ambition.

Workforce education, training and development

To ensure that clinicians can encourage behaviour change in their patients, work needs to go ahead with the local education and training boards (LETB). The work will aim to provide a renewed focus on the education and skill development of clinicians. It will be important to work with NHS England to enable this approach to succeed and make sure that the way clinicians are incentivised encourages these new ways of working.

Defining the future model of long-term conditions care in primary care

Working closely with the integrated and primary care strategic programmes, we need to describe a model for giving care to people with long-term conditions in primary care settings. Work is needed on considering how funding is set-up to support this.

Redesigning acute outpatient care

We need to change the current model of outpatient care to design a more accessible and responsive model that is available when needed, rather than it being wedded to routine practice. This model should maximise opportunities to use technology or work differently to reduce the need to travel to the hospital to access specialist input, and treat patients holistically avoiding the need for multiple appointments. We believe this will result in an improved patient experience and a reduction in unplanned care episodes. This is in line with the Academy of Medical Royal Colleges' (2014) recent recommendation to reduce unnecessary face-to-face contacts between patients and healthcare professionals by using technologies such as email and Skype⁷⁷.

Significant work started in October 2012 to redesign outpatient services at Barts Health through an 'outpatient transformation programme'. This aims to develop high-quality pathways, improve standards and explore how technology can support outpatient care. As part of this work, waits for colorectal continence pathways have improved from two months to two days and the number of services running one-stop clinics of multi-disciplinary teams has risen from four to eight. Telephone clinics have also been launched for cancer, colorectal, paediatric and neurology services.

This work has been published and presented locally and nationally⁷⁸. Areas of good practice should be rapidly expanded, allowing patients to be treated close to home where possible and stopping activity that adds limited value and needs a trip to hospital.

⁷⁷ Association of Medical Royal Colleges (2014): Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care

⁷⁸ Health Service Journal (6 October 2014): Keep up with change: The trusts transforming the outpatient pathway.

Improving mental health in the integrated care programme

The profile of mental health in the integrated care programme needs to be raised to ensure the full integration of mental health support for people with long-term conditions. There also needs to be training across the health and social care workforce to recognise symptoms of mental illness and ensure support is provided for them.

Working across the whole system to reduce the need for acute care

Work needs to be taken forward across the health and social care system to ensure that patients are only in hospital when they need clinical care – not because there is nowhere else for them to go or because of systematic inefficiencies that delay their discharge.

Feedback from patients has indicated that patients with long-term conditions receive most support to manage their condition from support and self-help groups operating outside of the NHS. We need to learn from, and work alongside, these organisations to provide people with the best support to manage their health. As Simon Stevens, NHS Chief Executive states in the *Five Year Forward View*, helping people with long-term conditions make informed choices regarding treatment, managing conditions and avoiding complications will go a long way to empowering them to feel in control of their conditions⁷⁹.

Engaging patients and the public in redesigning long-term condition care

Further work is required to actively engage and involve the population in co-designing services. Patients need to be supported by the system to be equal and active partners in service redesign. The London Health Commission recommended in their *Better Health for London Report* (2014) that health and social care professionals should partner with people who use services to ensure that their voice is heard in designing and implementing improvements to care⁸⁰. This is crucial if local NHS services are to support those with long-term conditions to gain better control of them.

Helping people to die in accordance with their wishes

We need to take action to improve care in the last years of life, including helping more people to die in their place of preference, through tailored and shared care planning. We should:

- work with patients and their families to better understand the care and support they would like in the last years of life
- raise skills in professionals and have clear pathways for end-of-life care
- explore how to meet the demand for nursing homes or care homes
- reduce unnecessary hospital admissions by ensuring high-quality 24-hour care is available in the community
- consider the provision of befriending services to improve quality of life in the last years.

⁷⁹ NHS England (2014): *Five Year Forward View* p12

⁸⁰ London Health Commission (2014): *Better Health for London*. p50

7.7 Unplanned care services

This section summarises the findings of the Unplanned Care Clinical Working Group, describing the context that services are operating in, the case for change, emerging priorities and new models of care.

Context

Four sites in east London provide 24/7 emergency departments: Homerton Hospital, Newham Hospital, The Royal London Hospital and Whipps Cross Hospital. Each of these also has an onsite urgent care centre (UCC). St. Bartholomew's has an onsite minor injuries unit. Mile End Hospital has no onsite emergency services.

The table below outlines the services at each site. The urgent care centres work slightly different hours.

Royal London (RLH)			
Minor Injuries	UCC (1200-2300)	Emergency department	Unscheduled surgery
Critical care unit	Intensive care unit	Stroke TIA	Hyper-acute stroke care
HAC	Burns Unit	Major trauma	Air ambulance

Whipps Cross (WXH)			
Minor Injuries	UCC (24/7)	Emergency department	Unscheduled surgery
Critical care unit	Intensive care unit	Stroke TIA	Hyper-acute stroke care
HAC	Burns Unit	Major trauma	Air ambulance

Newham (NUH)			
Minor Injuries	UCC (1000-2200)	Emergency department	Unscheduled surgery
Critical care unit	Intensive care unit	Stroke TIA	Hyper-acute stroke care
HAC	Burns Unit	Major trauma	Air ambulance

Homerton (HUH)			
Minor Injuries	UCC (0700-0100)	Emergency department	Unscheduled surgery
Critical care unit	Intensive care unit	Stroke TIA	Hyper-acute stroke care
HAC	Burns Unit	Major trauma	Air ambulance

St Bartholomew's (StB)			
Minor Injuries	UCC (24/7)	Emergency department	Unscheduled surgery
Critical care unit	Intensive care unit	Stroke TIA	Hyper-acute stroke care
Emergency arrhythmia	Burns Unit	Major trauma	Air ambulance

Mile End Hospital (MEH)			
Minor Injuries	UCC (1000-2200)	Emergency department	Unscheduled surgery
Critical care unit	Intensive care unit	Stroke TIA	Hyper-acute stroke care
HAC	Burns Unit	Major trauma	Air ambulance

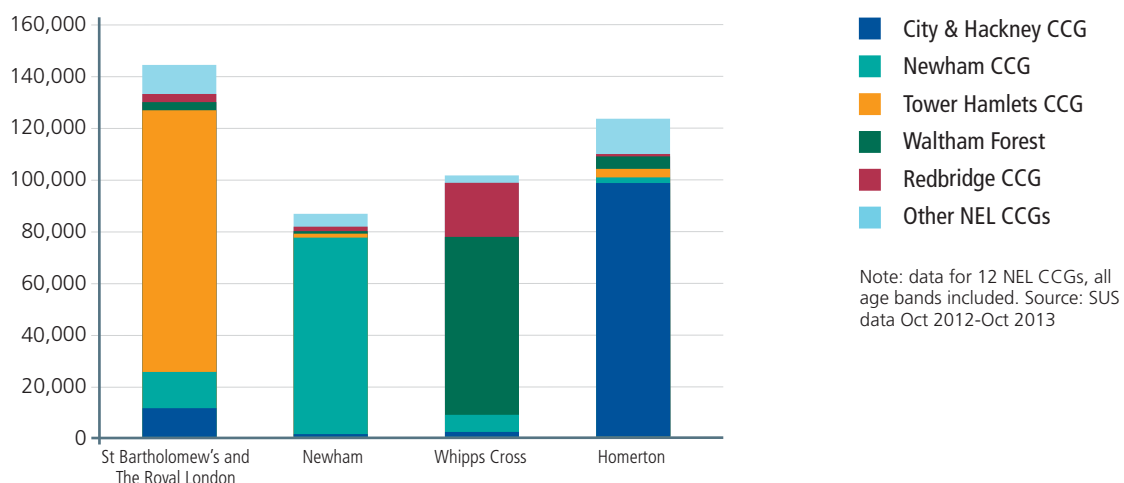
Each site operates a slightly different 'front door' model for their unplanned care services. This relates to how they stream patients, their ways of avoiding unnecessary admissions and their community in-reach approaches. The effectiveness of the hospital front door affects the flow of patients into each hospital. Urgent care is also provided outside a hospital setting, in primary care, community care and by the ambulance service. Its effectiveness can affect emergency pathways in acute trusts by providing alternatives to acute admission and helping to discharge patients.

The Royal London Hospital is a major trauma centre and has a hyper-acute stroke unit. Specialist cardiac services at The London Chest Hospital are due to transfer to St. Bartholomew's Hospital in spring 2015, making the site a heart-attack centre. A network operates to help hospitals access these specialist services.

Different levels of emergency care are provided across the sites in east London

Emergency departments (and in particular the urgent care centres at each site) provide different levels of care and work in different ways. In 2012/13, there were 458,000⁸¹ A&E attendances across the Barts Health and Homerton sites. Nearly a third (31%; 145,000 attendances) were at The Royal London Hospital; 27% were at Homerton Hospital (124,000 attendances); 19% were at Newham Hospital (88,000 attendances); and 22% were at Whipps Cross Hospital (102,000 attendances).

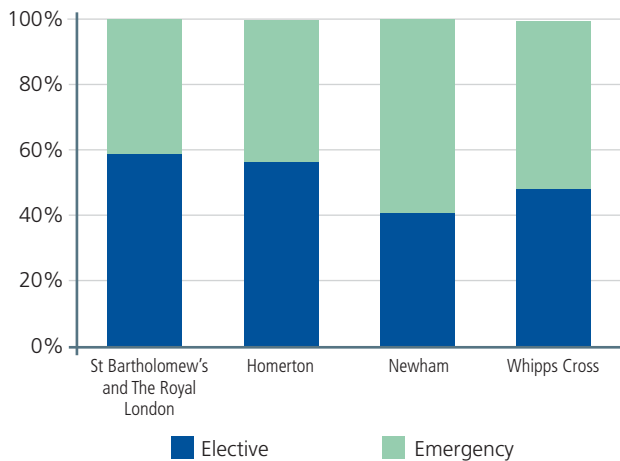
A&E attendances including urgent care centres (October 2013 - September 2013)



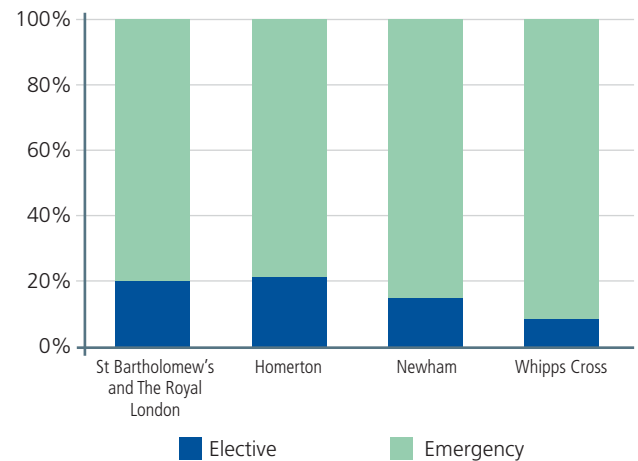
⁸¹ Figures rounded to nearest thousand

On average, emergencies account for 45% of all admissions to Barts Health and Homerton Hospital but 83% of bed days across all sites, and they have a longer length of stay than elective admissions. The average length of stay for emergency cases varies from 5.4 days at Newham Hospital to 8 days at The Royal London Hospital.

Emergency admissions as a percentage of all admissions by site



Percentage of all bed days accounted for by emergency admissions by site



Emergency and elective surgical services are provided at four sites in east London. This includes different levels of secondary care and specialist services

The Royal London Hospital provides the largest proportion of specialist surgical services, which reflects its status as a major trauma centre. This is likely to be because of the more complex mix of patients treated at The Royal London site for emergency surgery. Some specialist surgical services are available at all sites. Formal and informal transfer arrangements enable patients to access acute complex and specialist surgical services where these are only available in some hospitals. Each site performs emergency surgery at different volumes and there is considerable variation within specialties.

The diverse and complex nature of our population presents difficulties in providing unplanned care. As discussed in other sections, high levels of deprivation are linked to poor underlying health, lower life expectancy, a high prevalence of mental health conditions, as well as a greater need for social care support. Locally, we have some of the highest levels of deprivation in England.

Our diverse population: Tower Hamlets case study

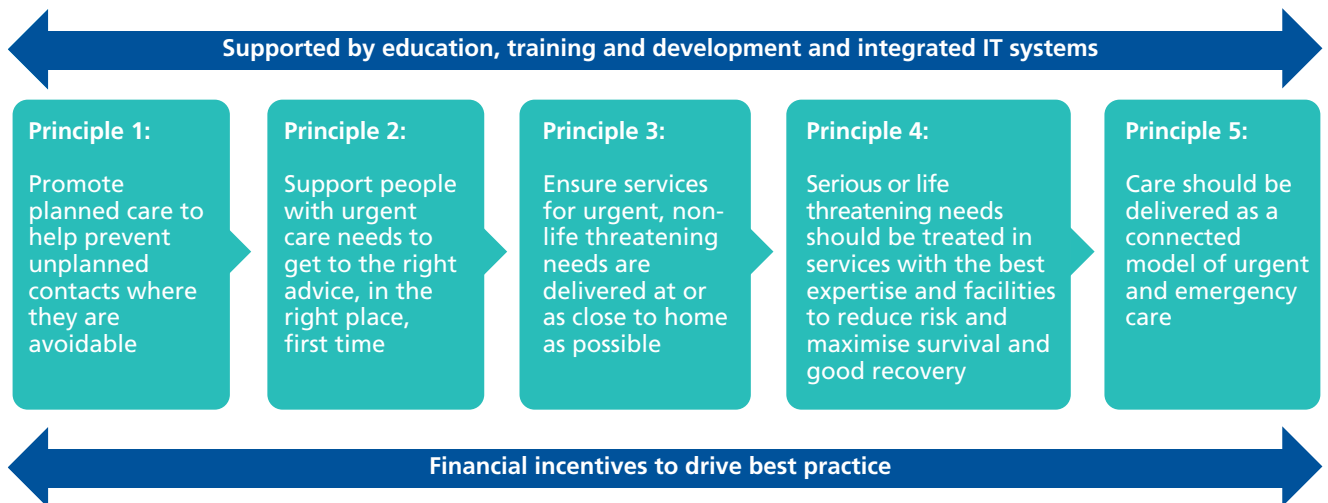
- Almost a third of patients in Tower Hamlets have English as a second language. Consultations for these patients last 1.9 times longer than for those who speak English as a first language
- There is a high level of movement into and out of the boroughs (e.g. Tower Hamlets has the eighth highest rate of population turnover in London, with 281 people moving each year per 1,000 population). This causes difficulty in providing continuity of care and increases the administrative burden for general practice
- A large part of the population is unregistered with GPs – for example, a third of patients attending St Andrew’s walk-in centre in Tower Hamlets and 30% of those who attend A&E
- A significant number of people working in the east London boroughs also want access to unplanned care services while in the area. For example, there are estimated to be 350,000 people a day entering the City and 100,000 people in Canary Wharf who may want access to healthcare
- There is a large homeless population in some parts of east London. The most recent data shows there are 326 rough sleepers in Tower Hamlets, a rise of 96 from 2008/9⁸².

Unplanned care: the case for change

- 1 The existing urgent-care system cannot continue working in the same way. We need to fix it, ensuring patients are seen in the right care setting for their needs.
- 2 The current system of unscheduled care is complex and confusing.
- 3 There is a significant opportunity to provide more care over the telephone or closer to home.
- 4 Improved ambulatory care would mean more patients would be able to go home after receiving the treatment they need.
- 5 New ways of working may mean more people can return home safely, earlier.
- 6 We need to design a new model of urgent care to ensure patients see the right clinician first time, based on strong local pathways. This model will need to consider whether consolidating (bringing together) of some services would be a more effective, responsible and sustainable use of our limited specialist resources (people, space and equipment).
- 7 We could make better use of capacity by studying hospital sites and, where suitable, separating emergency and elective surgery.

82 Combined Homeless and Information Network

The case for change has been developed by comparing current services with principles that the Unplanned Care Clinical Working Group has set out for good care:



The case for change is as follows:

1 The existing urgent-care system cannot continue working in the same way. We need to fix it, ensuring patients are seen in the right care setting for their needs.

Nationally, millions of patients each year seek or receive help for their urgent-care needs in hospital when they could have been helped much closer to home. Locally the picture is similar. A quarter of patients attending The Royal London Hospital Emergency Department (A&E and UCC combined) were discharged with 'no investigation and no significant treatment' and over 40% of attendances at Homerton Hospital were for low-level investigation and treatment (category 1 investigations with category 1-2 treatment). We know this data is imperfect and must be treated with caution, but it suggests there are many patients who could receive better treatment elsewhere.

Similarly, benchmarking shows large variation in the admission to hospital of people with long-term conditions who could be better managed in the community. These are known as 'chronic ambulatory care sensitive conditions'⁸³. Examples include conditions such as asthma and diabetes. City and Hackney has the lowest number of these admissions per 100,000 population in London, with 325 admissions compared to a national average of 1,182. Barking and Dagenham has the highest number of these admissions (1,406 per 100,000 population)⁸⁴.

If these conditions are better managed outside hospital (perhaps through changes in lifestyle), this reduces the need for hospital admission.

⁸³ Kings Fund (2013): Transforming our Health Care System: Ten priorities for commissioners. Chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management.

⁸⁴ Health and Social Care Information Centre (2014): CCG level breakdown from Hospital Episode Statistics (HES), Period 2012/13, ONS mid-year population estimates and GP registered patient counts from NHAIS (Exeter)

Access to services that avoid the need for A&E attendance and related admissions varies by borough. This variation is shown particularly in care planning for patients with long-term conditions and the support available to help them manage their own conditions. Local authorities have a crucial role within communities in preventing unplanned care episodes. Benchmarking of local authority spending in the east London boroughs shows significant variation of spending on public health, from £36 per head of population in Redbridge to £117 per head of population in Tower Hamlets, compared to a London average of £74.⁸⁵

2 The current system of unscheduled care is complex and confusing.

The urgent-care system has multiple points of entry. People can get urgent care advice by telephone (GP, out-of-hours services, NHS 111) or in person (walk-in clinics, urgent care centres, minor injury units). Each service offers a slightly different model, at slightly different times, in different places.

The urgent care system's complexity means people often 'default' to A&E. Not only is it a trusted brand but the service is highly responsive, with an average national wait of 50 minutes for treatment and the vast majority of patients seen within the four-hour target. The problem of A&E acting as a default is worsened by primary care access, which is variable across our area. There are also inconsistent social and community care arrangements in each borough. Some boroughs operate 24-hour services seven days a week; others do not. A study in Newham⁸⁶ A&E on the reasons for attendance found that **A&E was not the most appropriate care setting for 48% of attendees interviewed.**

There are, however, difficulties in achieving a better model for unplanned care through primary and community care. Local clinicians said that in Newham there are about 90 fewer GPs than are needed to serve the population; while in the whole of London there remains a significant shortage of district nurses qualifying in recent years. Nationally, in the past decade there has been a 40% decline in those choosing to enter the district nursing profession.

3 There is a significant opportunity to provide more care over the telephone or closer to home.

The opportunity to provide more unplanned care services closer to home is significant. The future model of unplanned care should ensure that those needing urgent, but non-life-threatening, treatment receive it at, or as close to, home as possible. Nationally, it is estimated that 50% of 999 ambulance call attendances could have been treated at the scene⁸⁷. The London Ambulance Service is committed to developing and growing its 'see and treat' and 'hear and treat' services so that its clinicians can provide more care and treatment at the scene.

85 YPHPO (2014): Spend and outcome tool (SPOT): local authorities. <http://www.yphpo.org.uk/resource/view.aspx?RID=203757>. [Accessed 2 September 2014].

86 P. Mayer, S. Roberts and C. Smith – 1st-year medical students at St. Bartholomew's and the Royal London (2005): A study into the reasons for attendance of patients to Newham General A&E. Sample size 133

87 NHS England (2013): High quality care for all, now and for future generations: Transforming urgent and emergency care services in England – Urgent and Emergency Care Review End of Phase 1 Report Superseded. <http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf>

There is a significant opportunity to maximise the role of community pharmacists in preventative activities. Locally, the majority of community pharmacies open from 9am to 6pm, with around half open until 1pm on Saturdays and a few open on Sundays. Most community pharmacies offer minor ailments services as well as private consultations for patients to discuss their medicines. However, few offer advanced services such as reviewing the use of health appliances, like stoma bags. It is not clear from the information available how well used any of these services are.

Evidence suggests that a large proportion of urgent care by GPs and other health professionals could be handled over the phone or through Skype/video conference. Modern technology would be more convenient for some patients, could increase the number of people helped, and would also free face-to-face appointments for those who most need or prefer them. A study in Newham of 111 calls transferred to the GP out-of-hours service found that over 50% of advice and treatment was given over the phone⁸⁸. In addition, the future model of unplanned care should include improved communication between community and hospital, whether that be face to face, via telephone or Skype or through a medical link. Currently, systems, processes and behaviour do not promote active communication and information sharing across organisational and professional boundaries, or promote the fact that all our clinicians have a role in providing unplanned care.

4 Improved ambulatory care would mean more patients would be able to go home after receiving the treatment they need.

The current arrangement and provision of services in east London means that the reason for admission at each hospital site is not always set by clinical need. Benchmarking data shows that emergency admission rates per 1,000 population vary between boroughs: from 115 in City & Hackney to 95 in Tower Hamlets. This compares to the national average of 109⁸⁹.

Ambulatory care services offer trusts an alternative to routine admissions. Ambulatory care provides the urgent care people need, without them needing to be admitted to hospital. The services can therefore help avoid unnecessary hospital stays, improve patient experience and ensure that limited acute resources are available and accessible to those who most need them. Currently, admission avoidance teams work in all four emergency departments in east London. However, to be effective, ambulatory care requires 'early decision-making and rapid access to diagnostics, as well as immediate access to support services in the community for optimised integrated care'⁹⁰. Evidence from local hospitals' self-assessment against the London Quality Standards for emergency departments suggests that these arrangements are not in place across all sites.

In addition, some sites cannot meet recommended standards for consultant cover, with variation seen between weekdays and weekends.

88 GP Co-Op Board Meeting papers (May 2014)

89 NHS England (2014): Commissioning for Value Tool

90 NHS Institute for Innovation and Improvement (2012): Directory of Ambulatory Care for Adults, Ambulatory Emergency Care Delivery Network, 3rd edition

Trusts' self-assessment against the London Quality Standards (Emergency Department)

Emergency department		Homerton Hospital		Newham Hospital		Royal London Hospital		Whipps Cross Hospital	
No.	London quality & safety standard:	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend
2	A consultant in emergency medicine to be scheduled to deliver clinical care in the emergency department for a minimum of 16 hours per day (matched to peak activity) seven days per week. Outside of these 16 hours a consultant will be on call and available to attend the hospital for purposes of senior clinical decision making and patient safety within 30 minutes.	Not met	Not met	Not met	Not met	Met	Met	Not met	Not met
3	24/7 access to the minimum key diagnostics. X-ray: immediate access with formal report received by the ED within 24 hours of examination. CT: immediate access with formal report received by the ED within one hour of examination. Ultrasound: immediate access within agreed indications / 12 hours with definitive report received by the ED within one hour of examination. Lab sciences: immediate access with formal report received by the ED within one hour of the sample being taken. Microscopy: immediate access with formal result received by the ED within one hour of the sample being taken. When hot reporting of imaging is not available, all abnormal reports are to be reviewed within 24 hours by an appropriate clinician and acted upon within 48 hours.	Met	Met	Not met	Not met	Met	Met	Not met	Not met

The Health Foundation's Flow Cost Quality programme⁹¹ found that a more important operational issue than overall demand is the availability of staff at the right times to meet demand. The programme also found that poor patient flow (how and when patients are admitted and discharged within hospitals) was associated with an increased likelihood of harm to patients and higher healthcare costs because of longer lengths of stay, higher bed occupancy and readmissions. Improved flow was associated with the opposite effects, as well as with improved patient and carer experience. Analysis found that when patients had to wait for senior assessment overnight or at the weekend, they were much more likely to be put on the wrong pathway. This led to a longer than necessary stay.

91 The Health Foundation (2013): *Improving patient flow: Learning report*

5 New ways of working may mean more people can return home safely, earlier.

Many factors affect the length of time a patient stays in hospital, some of which are beyond the hospital's control, such as the nature and severity of the illness or injury or the structure of services in the community and in social care. However, some factors can be influenced by the way the hospital works – for example, timely and proactive discharge planning; access to senior decision-makers; and clinicians and patients receiving prompt test results. A review of the trusts' self-assessment against the London Quality Standards shows there is variation between sites, and different processes in place during the week than at weekends, for example in the frequency of daily ward rounds in acute medical units, access to key diagnostics and discharge planning.

Trusts' self-assessment against the London Quality Standards (acute medicine)

No.	Emergency department	Homerton Hospital		Newham Hospital		Royal Hospital		Whipps Cross Hospital	
		Weekday	Weekend	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend
6	All patients on acute medical and surgical units to be seen and reviewed by a consultant during twice-daily ward rounds, including all acutely ill patients directly transferred, or others who deteriorate.	Not met	Not met	Met	Not met	Not met	Not met	Not met	Not met
7	All hospitals admitting medical and surgical emergencies to have access to key diagnostic services in a timely manner 24 hours per day, seven days per week to support clinical decision making. Critical: imaging and reporting within 1 hour. Urgent: imaging and reporting within 12 hours. All non-urgent: within 24 hours.	Not met	Not met	Met	Met	Met	Met	Met	Not met
12	All admitted patients to have discharge planning and an estimated discharge date as part of their management plan as soon as possible and no later than 24 hours after admission. A policy is to be in place to assess social services seven days per week. Patients to be discharged to a named GP.	Not met	Not met	Met	Met	Met	Met	Not met	Not met

Effective working and reducing the length of stay ensures there are free beds for those who need them most. To achieve this, discharge systems need timely access to support services and teams. Data on delayed transfer of care shows that the health and social care services could work together on this more efficiently. For example, in 2012/13 discharges were delayed for 457 patients at Barts Health. 26% of delays were for patients awaiting further NHS non-acute care and 19% were awaiting completion of an assessment. At Homerton Hospital, 35% of delayed transfers of care were for patients awaiting a care package in their own home.

The accessibility of community and social care services significantly affects length of stay and the ability to discharge patients appropriately. Currently, the community and social care service arrangements differ by borough. Newham runs a seven-day-a-week social care service but Tower Hamlets and Waltham Forest do not, although work to develop the service has started.

Access to neuro-rehabilitation services is cited as a particular cause of delays, with Barts Health estimating that patients waited up to 50 extra days on average in hospital for transfer to a neuro-rehabilitation unit and placement in 2012/13. These delays expose vulnerable patients to increased risk of secondary complications like hospital-acquired infections and affect their potential for longer-term recovery and longer-term quality of life⁹².

6 We need to design a new model of urgent care to ensure patients see the right clinician first time, based on strong local pathways. This model will need to consider whether consolidating (bringing together) some services would be a more effective, responsible and sustainable use of our limited specialist resources (people, space and equipment).

The Royal College of Surgeons⁹³ states that safe and efficient emergency general surgery requires the following services and facilities:

- sufficient dedicated emergency theatre access
- sufficient access to on-call surgical teams (numbers/expertise)
- anaesthetists and critical-care doctors along with intensive therapy/high dependency resources
- interventional and diagnostic radiologists
- dedicated emergency beds
- where children are admitted, inpatient paediatrics and specialist children's facilities.

The current set-up means not all sites have all these services and facilities in place consistently throughout the week. There is now an opportunity to look together at how we provide services at all sites to provide the best possible care for patients in a sustainable way.

There is evidence in some specialties that providing complex care in higher volumes produces better outcomes. But the Royal College of Surgeons says a safe and efficient emergency surgical service could be provided on both a specialist and local basis as long as the above requirements are met. A local example of this is the way Homerton Hospital transfers a significant share of complex emergency surgical cases to The Royal London Hospital as its closest provider of specialist surgical services; Homerton Hospital is still able to maintain a full general surgery rota through also offering a specialist bariatric service, which requires a team of upper gastro-intestinal surgeons.

⁹² Barts Health (2014), Developing Neurosciences - neuro-rehabilitation services

⁹³ Royal College of Surgeons (2013): Emergency General Surgery. www.rcseng.ac.uk/healthcare-bodies/docs/emergency_general_surgery.pdf

Consultant surgical training and requirements for service delivery are changing. Specialties that have previously been part of one team and one rota will separate into three rotas of subspecialists. This means it will become increasingly hard for staff rotas to meet recommended national guidelines.

We know that surgeons in some hospitals treat fewer patients. Evidence shows that doing more surgical procedures means better outcomes and that surgeons need to do a minimum number to maintain their expertise.

There are a number of workforce difficulties in supporting services locally:

- Theatre nursing staff: there is a national shortfall in trained theatre staff. Barts Health has 60 vacancies, so it relies heavily on bank and agency staff. This is less cost effective and may lead to inconsistent and lower-quality care.
- Anaesthetists: there has been a reduction in anaesthetic training posts nationally. This has local effects as trainees are part of the teams covering the on-call rota. Consultants will be relied on to cover the shortfall. This in turn affects elective surgery – if consultants are covering on-call, they cannot cover elective lists the next day.

7 We could make better use of capacity by studying hospital sites and, where suitable, separating emergency and elective surgery.

Patients' operations are sometimes cancelled or delayed because others with life-threatening conditions take priority. Theatre capacity is limited by both physical space and the limited number of highly skilled staff. As a result, emergency surgical activity at the site directly affects how quickly people waiting for less-urgent operations can be treated and discharged.

Wards are set up to cater for both emergency and elective cases, allowing capacity to be flexed between them. However, at sites with high levels of emergency activity, this can mean longer hospital stays for patients who do not have life-threatening conditions but cannot be discharged until after an operation.

Demand and capacity initial analysis⁹⁴ done at Barts Health has found that about 230 hours a week of extra operating time will be needed to cope with future demand. This large number shows there is clearly a need to use capacity better across all sites. The work also found that up to an extra 25 beds will be needed across the trust to cope with the total projected increase in demand (based on previous years' growth).

**“Too many
people using A&E as
first access point”**

***Male Redbridge service user,
aged 26-40 (also NHS staff)***

⁹⁴ Demand and Capacity Programme led by Diana Lacey and Simon Harrod

Emerging priorities and models of care

Based on the clinical working group's analysis, we set out below the main emerging priorities and models of care.

We need to fix our urgent-care system, ensuring patients are seen in the right care setting for their needs

Local services need to develop models of urgent care that have consistent standards, are easy to navigate and are co-ordinated effectively between acute, 111, primary care and pharmacy services. In doing so, they need to take into account the recommendations of the Sir Bruce Keogh *Urgent and Emergency Care Review*. A next step will be to work with local urgent-care boards to conduct detailed capacity and demand analysis. This would review the benefits and constraints of local provision in each borough so that options for improvement can be considered.

Tackling a confusing and complex urgent-care system

Discussions have clearly concluded that a 'one size fits all' approach to urgent care would not suit east London's specific health needs. But the clinical working group agreed there are opportunities for more collaboration and coordination to improve outcomes and help patients navigate the system better.

Promoting and better using planned care programmes such as integrated care and care planning to reduce the burden on unplanned care services

We need to ensure that the existing unplanned care programmes across east London closely align to the WELC Integrated Care Collaborative, particularly in monitoring impact. This would help increase the amount of planned care, with a dramatic reduction in unplanned care episodes for people with long-term conditions. Health and wellbeing boards will have a central role in ensuring that local authorities can do more to tackle the wider factors affecting health.

In addition, we need to work closely with patients and their representative groups to explore how the NHS can better support them in managing their own health. However, we need to think about the language we use to describe this, as some patients have reported that it implies the NHS is discharging responsibility. We need to use language that is clearer about a partnership approach to healthcare delivery.

Provide more care over the telephone, or closer to home

Work is needed across the sector and with NHS England to increase the role of community pharmacy in providing urgent care and ensuring that this is integrated into pathways for urgent-care provision, such as 111. In addition, we need to increase the role of acute specialists in providing unplanned care and supporting GPs through systematic use of telephone and Skype advice, all formalised through the urgent-care pathway.

Ensuring that clinical need is the reason people are receiving hospital-based care

Commissioners and providers will need to work together to explore the opportunities for improved and extended care, and to support early decision making, rapid access to diagnostics and immediate access to community support services. This work will need to align with community services programmes to help avoid hospital admissions. It will also need to include work by commissioners of health and social care to review the out-of-hours service in community and social care services that will support effective discharge of patients, with a specific focus on dementia and neuro-rehabilitation discharge pathways.

Commissioners and providers will need to work together to develop a robust plan for meeting the London Quality Standards on consultant cover in A&E and for acute medicine. The goals are to ensure they follow the evidence-based approach for admission and support effective discharge planning.

Providing safe and efficient emergency surgical services as recommended by the Royal College of Surgeons

There is a clear case for change in terms of improving emergency surgical services. We now need to take forward a strategy for future emergency surgery across the Barts Health sites so that we ensure patients in east London get the best outcomes. We also need to tackle the workforce problems that are arising because surgical work is becoming more specialised. We must take into account, too, the importance of collaboration with community healthcare providers for rehabilitation and reablement, as mentioned above.

Strengthening the network model of providing urgent and emergency care

Local urgent-care boards need to co-operate to discuss the strengths of their urgent-care networks, both within and across their geographical areas, to ensure that local clinical interactions bridge the gaps between primary and secondary care. These discussions could focus strongly on the recommendations in the Sir Bruce Keogh *Urgent and Emergency Care Review*.

“There should be designated areas purely for elective surgery, run by surgeons”

Barts Health staff member

7.8 Planned care: elective surgery services

This section summarises the findings of the Elective Surgery Clinical Working Group, giving an overview of the context that local services are operating within, the case for change and emerging priorities and models of care for the future.

Context

Emergency and elective surgical services are provided across four sites in east London and the City. This includes varying levels of secondary care and specialist services. The diagram below shows the split of surgical services across the four sites, with the darker-shaded boxes showing specialist surgical services. The Royal London Hospital has the largest share of specialist services, partly because it is a major trauma centre. This means The Royal London site is likely to treat a more complex case mix for emergency surgical procedures. Some specialist surgical services are available across all sites. But formal and informal transfer arrangements enable patients to access acute complex and specialist surgical services wherever they are available.

Elective surgical services across east London hospitals

There are pockets of good practice. But the clinical working group agreed that some types of surgical services could be more effective and lead to better outcomes for patients. This does not reflect on the skills of individuals or teams but on the systems in which they work.

Locally, we face problems from the legacy Barts Health trusts in finance, workforce, IT and estates. We also face the problems of the wider health system. In particular, the health economy has to make further financial savings and work in an area where deprivation is high and the population is increasing. This is why it is important to consider whether providing similar planned services across sites is the most efficient and sustainable use of our finite specialist resources, in terms of people and equipment.

St Bartholomew's and The Royal London		
Bariatric surgery	Specialised cancer	Cardiac surgery
Specialised colorectal	Complex surgery	ENT
Specialist ear	Gastroent.	Gynaecology
Hepatobiliary	Neurosurgery	Oncological surgery
Oral / maxfax	Orthopaedic	Plastic surgery
Renal transplant	Thoracic surgery	Trauma surgery
Urology	Specialised urology	Vascular surgery

Whipps Cross		
Bariatric surgery	Specialised cancer	Cardiac surgery
Specialised colorectal	Complex spinal surgery	ENT
Specialist ear	Gastroent.	Gynaecology
Hepatobiliary+ pancreas	Neurosurgery	Oncological surgery
Oral / maxfax	Orthopaedic	Plastic surgery
Renal transplant	Thoracic surgery	Trauma surgery
Urology	Specialised urology	Vascular surgery

Newham		
Bariatric surgery	Specialised cancer	Cardiac surgery
Specialised colorectal	Complex spinal surgery	ENT
Specialist ear	Gastroent.	Gynaecology
Hepatobiliary+ pancreas	Neurosurgery	Oncological surgery
Oral / maxfax	Orthopaedic	Plastic surgery
Renal transplant	Thoracic surgery	Trauma surgery
Urology	Specialised urology	Vascular surgery

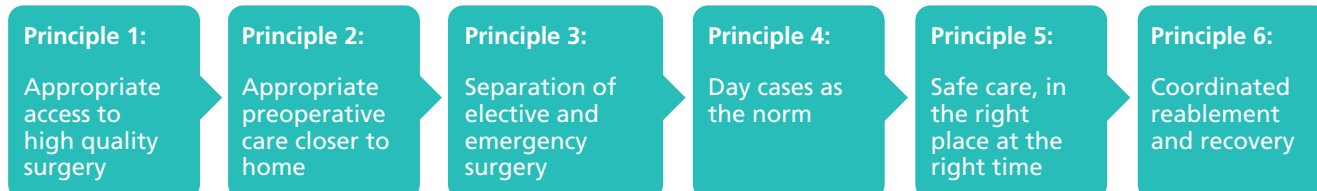
Homerton		
Bariatric surgery	Specialised cancer	Cardiac surgery
Specialised colorectal	Complex spinal surgery	ENT
Specialist ear	Gastroent.	Gynaecology
Hepatobiliary+ pancreas	Neurosurgery	Oncological surgery
Oral / maxfax	Orthopaedic	Plastic surgery
Renal transplant	Thoracic surgery	Trauma surgery
Urology	Specialised urology	Vascular surgery

*Specialised colorectal has moved to Royal London

Planned care: elective surgical services – the case for change

- 1 There is an opportunity to better use surgical capacity across sites. This is because the current demands of emergency and elective surgery mean that sometimes elective operations are cancelled due to lack of capacity and issues relating to patient flow.
- 2 There is an opportunity to look at how services could be brought together to ensure surgeons meet national guidance and use theatres and staff effectively.
- 3 Consolidation (bringing together) of some surgical services would mean that dedicated resources could be used to implement enhanced recovery.
- 4 Barts Health and Homerton Hospital could provide best-in-class services for day-case procedures.

We have developed the case for change by comparing current services with principles that the Elective Surgery Services Clinical Working Group has set out for good care.



The case for change is as follows:

- 1 There is an opportunity to better use surgical capacity across sites. This is because the current demands of emergency and elective surgery mean that sometimes elective operations are cancelled due to lack of capacity and issues relating to patient flow.**

In 2012/13, 52,674⁹⁵ patients were admitted for surgery in east London and the City. Of those admissions, 74% were admitted for elective surgery, although there is much variation within specialties and across sites.

⁹⁵ SUS data October 2012 to September 2013: Non-elective and elective admissions under a surgical specialty by site

The proportion of emergency and elective procedures by site (October 2012 – September 2013)⁹⁶

	Emergency admissions	Elective admissions	Elective admissions as % of total
St.Bartholomew's and The Royal London	6,826	16,291	70%
Homerton	1,972	10,427	84%
Newham	4,315	8,736	67%
Whipps Cross	5,169	17,220	77%

This data shows a large variation in the proportions of elective and emergency surgery on sites. Nationally, 84% of procedures are elective⁹⁷.

Some of this variation reflects The Royal London Hospital's role as a major trauma centre and provider of specialist services with transfer arrangements in place between sites. For example, The Royal London Hospital provides acute complex and specialist provision for surrounding hospitals (such as trauma and neurosurgery) and takes out-of-hours cases for services usually provided within normal hours at surrounding sites (e.g. vascular surgery).

This complex tertiary work in particular can significantly affect the overall pattern of non-elective work in hospitals⁹⁸. Discussion at the clinical working group suggested that the greater complexity of cases seen at The Royal London Hospital affects the non-elective flow of patients in the trust. This is discussed in detail in the appendix pack for Elective Surgery Services.

This programme provides an opportunity to look across sites and use capacity better through:

- **Enhanced core surgical services**, through the local provision of lower-risk procedures where efficiencies cannot be gained from bringing these services together. This local surgical service should underpin current maternity and emergency services.
- **Using local facilities such as the Newham Gateway Centre for higher-volume elective surgery.** These new facilities already exist and could deliver benefits by providing dedicated elective services.
- **Formal protocols and surgical assessment to ensure that elective patients receive the most suitable care at the right time.** This would involve bringing together resources and related clinical services in a way that improves outcomes and redistributes demand in line with capacity across sites.

⁹⁶ SUS data October 2012 to September 2013: Non-elective and elective admissions under a surgical specialty by site. Extracted 30/07/14

⁹⁷ National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) (2003)

⁹⁸ Ibid

2 There is an opportunity to look at how services could be brought together to ensure surgeons meet national guidance and use theatres and staff effectively.

The training of surgical staff has changed a lot over time and surgical training has become more specialised. Currently, because similar elective services are offered across four sites, surgeons in some hospitals see low numbers of patients. Evidence shows that a higher number of patients can lead to better outcomes⁹⁹.

National guidance shows that surgeons will need to do a minimum number of operations within their specialty. With the current set-up of services and activity, it will be more difficult to meet national guidance at all sites and ensure the best possible outcomes. So we need to review how we provide surgical services locally and ensure that new rotas meet the required criteria across sites for the elective part of the surgical pathway.

With some types of procedure being provided at several sites, the lower number at each site makes full theatre rotas harder to plan and maintain. This results in theatre usage varying across sites. Initial analysis shows that although theatre usage varies between site and specialty, there is a clear opportunity to improve and maximise productivity¹⁰⁰ and reduce waiting times. At an organisation and clinical commissioning group level, referral to treatment performance (the 18-week target) varies across east London and the City and across specialties. Performance data in March and April 2014 shows that Barts Health underperformed with an overall rate of 83%, failing to achieve the 90% standard in nine specialties, whereas Homerton Hospital achieved the standard with 91%.¹⁰¹

Best practice also shows clear benefits in separating surgeons' elective and emergency commitments for outcomes and efficiencies. However, recent sub-specialisation means emergency and elective surgical commitments are harder to separate while ensuring that skilled staff are used effectively. Emergency and elective surgical commitments are now separated for some specialties on some sites. But this is not the case at all of them.

This result is that dedicated elective resources (beds and equipment) are hard to ring-fence as their use cannot be guaranteed. Pressures from emergency commitments on bed capacity sometimes mean that operations are cancelled for non-clinical reasons. Initial analysis shows that at The Royal London Hospital, many operations are cancelled due to lack of capacity. The availability of both high-dependency unit beds and ward beds, as well as limits on theatre capacity, contribute to most cancellations. We know that as a result, too many patients are waiting too long for their operation.

99 M. M. Chowdhury, H. Dagash and A. Pierro: A systematic review of the impact of volume of surgery and specialization on patient outcome. <http://onlinelibrary.wiley.com/doi/10.1002/bjs.5714/pdf>

100 Utilisation data, Barts Health

101 NHS England: Consultant-led Referral to Treatment Waiting Times Data 2014-15. Figures rounded to nearest percent

3 Consolidation (bringing together) of some surgical services would mean that dedicated resources could be used to implement enhanced recovery.

Much enhanced recovery work takes place before patients have their operations. It helps ensure they are prepared for surgery and that suitable steps are taken in advance to aid their recovery. There are four major pathways for enhanced recovery – urology, orthopaedics, gynaecology and colorectal. Barts Health now runs enhanced recovery in three of the four areas. But this is not consistent across sites so significant improvement is possible. Enhanced recovery is in place at Homerton Hospital across all major pathways.

Implementing best-practice enhanced-recovery pathways is easier when there are many patients attending a site or specialism because we can then allocate specific resources. The opposite is also true: if there are few patients, it is hard to maintain dedicated resources e.g. viable and compliant critical care teams.

Data from east London and the City hospitals shows variability in the average length of stay for different elective procedures. Some of this may arise from the complexity of cases, but the variation reveals an opportunity to improve performance and safely get people home more quickly. For example, there is a variation of two days in average length of stay for intermediate knee procedures (non-trauma without complication) depending on the site at which patients received treatment. Variation is only one day for major hip procedures (non-trauma, category one)¹⁰².

So some patients are staying in hospital longer than necessary. Enhanced recovery, starting before admission, would help people at all sites return home safely, earlier.

4 Barts Health and Homerton Hospital could provide best-in-class services for day-case procedures.

Barts Health and Homerton Hospital generally carry out a higher proportion (which is generally considered better) of day-case procedures (compared with inpatient procedures) than their peers. But there is an opportunity to become even better by defining a set of low-complexity procedures and developing a specific high-quality local surgical service. This would allow for dedicated preoperative and postoperative care and education of patients to increase the availability of local provision of day-case surgery.

Local surgical services could also be improved by bringing together some high-volume, low-complexity procedures. This would enable us to ring-fence dedicated capacity and equipment, which would further improve outcomes. We could then send more patients home earlier safely, free capacity by using fewer beds, and enable the trusts to achieve best-practice tariffs in performing some day-case procedures as outpatients.

102 SUS Data 2013/14 using the top 5 HRGs (Health Resource Groups) excluding day-case and out-patient appointments

Emerging priorities and models of care

Based on the clinical working group's analysis, we set out below the main emerging priority and models of care.

Do more analysis and develop options for providing services across sites to provide higher-quality care in a more sustainable way

The longer-term underlying issues discussed above cannot be tackled at individual site level in the current services set-up. We need to look at the way we provide services across all Barts Health sites to provide the best possible care for patients. This should involve bringing together elective surgical services where this provides more effective and efficient care and offers an opportunity to strengthen local surgical services, by ensuring that high-quality surgery underpins maternity and emergency services.

A suitable grouping of services could provide:

- higher numbers of patients for more effective care with dedicated specialist consultant cover
- more experienced staff with dedicated resources for enhanced recovery and higher proportions of day-case and outpatient procedures (compared with inpatient procedures)
- steadier flow of patients to enable better planning and use of resources, and fewer cancellations
- the potential to provide dedicated pre- and postoperative care that improves shared decision making, preoperative quality of care and safely reduces length of stay.

"Diagnostic services are often miles away from hospital. Diagnostics should be used to underpin radical change ... We could have a walk-through diagnostics service, with the results available before the appointment"

Barts Health staff member

"If my Consultant appointment is at 4pm and is delayed, and I get sent for a blood test, but phlebotomy closes at 5pm, I have to come back the next morning. That means more time off school and work"

Mother of 14-year old daughter with ulcerative colitis. (Newham resident)

7.9 Clinical support services

This section summarises the findings of the Clinical Support Services Clinical Working Group, giving an overview of the context that local services are operating within, the case for change and emerging priorities and models of care for the future.

Context

Clinical support services (CSS) are provided across all Barts Health sites and Homerton Hospital. All sites provide pathology services (both phlebotomy and taking samples). However, to enable economies of scale, sites manage the processing of specimens differently. For example, high-volume services, such as haematology and clinical biochemistry, are provided across all sites, whereas lower-volume services, such as virology and cytology, are processed at The Royal London Hospital for all sites. This arrangement applies to Homerton Hospital too – cellular pathology, cytology and some virology are processed by The Royal London Hospital pathology laboratory. Therefore the activity listed below for Barts Health will include some Homerton Hospital activity for those services. The Homerton Hospital pathology laboratory processes a range of tests including microbiology, haematology, clinical biochemistry, virology, histopathology and phlebotomy. Approximately 60% of activity is associated with clinical biochemistry.

In 2013/14, Barts Health did 15.9 million pathology tests¹⁰³. Demand varies significantly by referral source: 60% of pathology activity arises internally (from A&E, inpatient, outpatient and sexual health clinics) and 36% of activity is generated by GP referrals. In 2013/14 Homerton Hospital completed 1.2 million GP-requested pathology tests in addition to its own hospital testing.

In 2013/14, Barts Health completed 673,688 radiology examinations. Radiology services are provided across all sites with more specialist imaging, such as 24-hour interventional radiology, provided at The Royal London Hospital. Networks enable patients from elsewhere to access these more specialist services. The Homerton Hospital provides plain film and ultrasound services. In 2013/14, 23,816 radiology GP-referred examinations were completed, 58% were for plain film x-rays and 42% were for ultrasound. Each of the main sites has an on-site hospital pharmacy, and Newham and The Royal London hospitals both have community pharmacies on site too.

“There should be virtual clinics for routine check-ups – this would make it easier for patients, and reduce the amount of ‘did not arrives’”

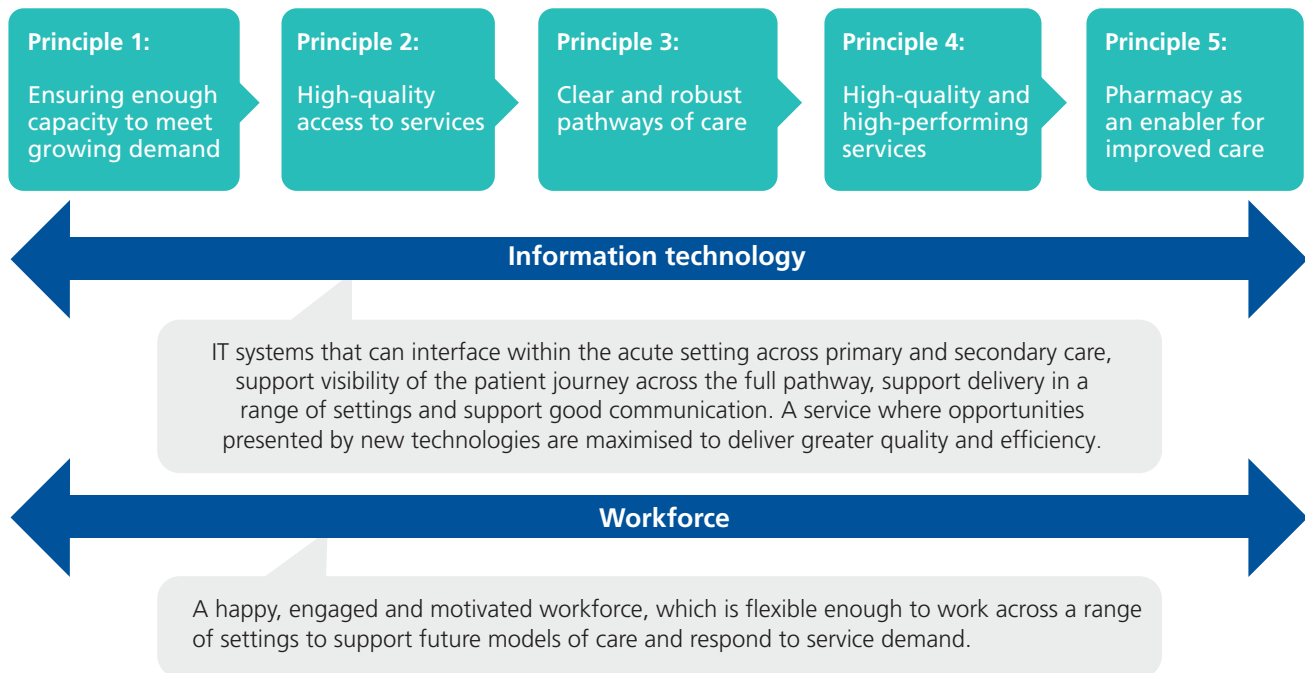
Barts Health staff member

¹⁰³ Includes some activity generated by the Homerton (68,408 or 0.4%) across virology, cellular pathology, clinical biochemistry, haematology and cytogenetics (in order of biggest volume). Source: Barts Health Pathology Data Warehouse extracted April 2014

Clinical support services: case for change

- 1 We need to plan effectively for the rising demand in diagnostics. This should take into account the types of test needed, the changing population and the prevalence of long-term conditions.
- 2 We want to ensure equity of access to the latest diagnostic techniques across east London. This includes ensuring that patients receive the tests they need while minimising wasted resources.
- 3 Developments in new technology and future models of care require us to look at how clinical support services will need to work differently and plan for this.
- 4 Moving to 24/7 services offers the chance to improve access and the speed of clinical decision-making.
- 5 There is an opportunity to streamline pathways by providing high-quality direct-access testing to everyone.
- 6 Adopting new technologies at scale across east London could maximise benefits and pave the way for new treatments and ways of working.
- 7 There is the opportunity to develop testing that is closer to patients' homes, minimising wasted time for patients and clinicians.
- 8 We can improve clinical decision making in primary care through clearer local diagnostic pathways.
- 9 Performance could be improved further by ensuring we measure the things that matter to clinicians and patients.
- 10 We could improve care by developing effective methods of communicating with primary and community care on discharge.
- 11 Pharmacists working in new ways can be vital in getting people home quicker.
- 12 Community pharmacists could provide some care closer to home.
- 13 We need to work hard to tackle local issues to ensure that IT is an enabler rather than a barrier to integrated care and enables new ways of working.
- 14 The move to 24/7 services will bring with it further challenges for attracting and retaining the highest-calibre workforce for clinical support services.

The case for change has been developed by comparing current services with principles that the Clinical Support Services Clinical Working Group has set out for good care:



The case for change is as follows:

1 We need to plan effectively for the rising demand in diagnostics. This should take into account the types of test needed, the changing population and the prevalence of long-term conditions.

Our population is growing 50% faster than the London average. This is expected to lead to an increase in demand for healthcare services, including clinical support services. Using Greater London Authority population projections¹⁰⁴, pathology activity from major commissioners is predicted to grow by 10.6% from 2013/14 to 2020/21. This means an extra 1.7m tests. 2014/15 is predicted to have the highest growth of 1.96% or 284,799 extra tests. The rate of growth is predicted to slow after that, but it is still significant, dropping to 1.26% by 2010/21 or an extra 202,566 tests.

The increasing prevalence of some long-term conditions, and an emphasis on early identification and diagnosis of people, are also driving demand. In Newham the prevalence of diabetes will be 56.8% higher than the national average in 2030¹⁰⁵. Based on these changes, the demand for pathology services will rise.

¹⁰⁴ No age-band growths have been applied – pathology data by age band were not available at the time of writing. The same growth assumptions have been applied to all sources and disciplines of activity. Only one year's worth of activity data is currently available. GLA population growth trends for Barking and Dagenham, City and Hackney, Newham, Redbridge, Tower Hamlets and Waltham Forest. Source: Barts Health Pathology Data Warehouse extracted April 2014 and Greater London Authority population growth.

¹⁰⁵ National Diabetes Information Service www.yhpho.org.uk/default.aspx?RID=154049

The current set-up of services (capacity, workforce, and infrastructure) is unlikely to sustain such growth in a way that maintains quality and performance.

There is no long-term joint plan in the local NHS for future diagnostic provision. The only solution currently is to increase resources, which is not financially viable, long term. This is particularly relevant given the variation in current performance.

2 We want to ensure equity of access to the latest diagnostic techniques across east London. This includes ensuring that patients receive the tests they need while minimising wasted resources.

The NHS Atlas of Variation in Diagnostic Services is designed to help the local NHS understand whether the variation in the rates of diagnostic services in their area is warranted (i.e. true clinical variation) or caused by other factors such as poor access to services or the need for education.

There is variation in the use of diagnostic testing in north east London. For example, the estimated annual use of blood glucose (fasting) tests ordered by GPs per 1,000 practice population ranges from 4 in Waltham Forest to 154 in Redbridge¹⁰⁶. Further work is needed to understand whether the variation is warranted or not, particularly as diagnostics can reduce much more costly care later on for the patient.

The clinical working group has grouped potential reasons for over-investigation as follows:

- Unnecessary rework: this can be due to tests being reordered because results do not appear in the patient record, tests are reordered as the result is thought 'lost', or the clinician cannot see results already requested because the test was done too recently. In some cases, lack of knowledge results in tests being done more often than is suitable.
- Lack of confidence, resulting in 'defensive clinical practice' and tests being requested 'to be safe'.
- Lack of knowledge about the most suitable test to use, alternatives to the test and the tests on offer locally.
- Pressure from patients to receive tests they think they need.

The group said the root cause of this is clinical behaviour, and that secondary-care clinical-support-service experts could, with suitable resources, take a much more active role in demand management and improve clinical knowledge and confidence.

3 Developments in new technology and future models of care require us to look at how clinical support services will need to work differently and plan for this.

The clinical working group said previous service set-ups and developments have not always included clinical support services as part of the planning process, e.g. Newham Gateway Centre. This has resulted in slower uptake of these new facilities and difficulty in ensuring high levels of use.

¹⁰⁶ NHS Atlas of Variation: Diagnostic Services, 2012/13 data (<http://www.sepho.org.uk/extras/maps/NHSAtlasDiagnostic/atlas.html>)

4 Moving to 24/7 services offers the chance to improve access and the speed of clinical decision-making.

NHS England's vision for seven days a week services includes specific ambitions for clinical support services¹⁰⁷.

We want to meet the standards in a clinically and financially sustainable way. This will mean transformational change and cooperation between service providers and different sectors of the health and social care system.

A mapping exercise has helped us understand which clinical support services are needed to support a 24/7 model locally, along with national standards for seven-day services. Main findings of this work:

- Network arrangements are helping the trusts meet many of these standards for urgent patients. But in other cases, issues still need to be resolved to ensure that standards are being met across all sites
- There is difficulty in dealing with some patients classed as critical (needing advice or diagnostics within an hour) out of hours. This is because the clinician interpreting the test must deal with a complex, but also broad, case mix. A single consultant may not be able to provide this depth of knowledge across the trusts
- The current network arrangements for interventional radiology rely on rapid transfers and beds being available at The Royal London site. Capacity restrictions are affecting bed availability and therefore access to this service
- An important pressure point is demand from the urgent-care system. We need to look at this more closely regarding the over-investigation of cases
- Diagnostic and scientific workforce issues are an important limitation on providing seven-day services across England. The group agreed this was also a local concern. The main difficulties include recruiting and retaining skilled staff, getting the right skill-mix, compliant staff rotas, and the need for changes to current terms and conditions and contracts if the services move to a 24-hour, seven-day-a-week model.

5 There is an opportunity to streamline pathways by providing high-quality direct-access testing to everyone.

Most direct access provision is acute based and operates mainly within working hours (9-5pm). Existing direct access to 'Any Qualified Providers' of diagnostic services has been of varying quality. The group reported that the quality of images often means tests need to be repeated. It said this was because of differences in equipment quality and systems that couldn't work with each other.

Local clinical commissioning groups have recently decided to re-procure this service. They will not retain every type of test in future. The types they do retain will vary between boroughs, so there will be differences in future diagnostic provision across north east London.

¹⁰⁷ NHS England (2013): Seven day services. <http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf>

6 Adopting new technologies at scale across east London could maximise benefits and pave the way for new treatments and ways of working.

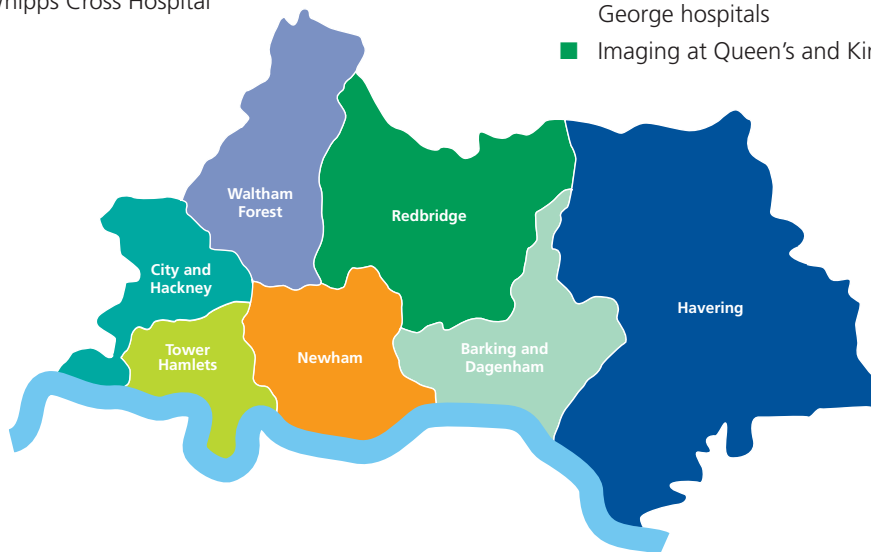
The group discussed the variation in access to some of the newer technologies across our area. We summarise some of these in the diagram below:

Waltham Forest

- Near site testing/phlebotomy in some practices
- Phlebotomy through ELFT and Whipps Cross Hospital
- Tendering for direct access US, MRI, audiology and physical measurement
- Imaging at Whipps Cross Hospital

Barking, Havering and Redbridge

- Phlebotomy through NELFT at Chadwell Heath, Church Elm, Lane Marks Gate, Porters Avenue, Thames View Health Centre, Vicarage Fields
- Upney Walk-in Centre, domiciliary service for housebound patients and at Queen's and King George hospitals
- Imaging at Queen's and King George hospitals



City and Hackney

- Near site testing/phlebotomy in some practices
- Phlebotomy at Homerton University Hospital (HUH)
- Imaging at HUH

Tower Hamlets

- Near site testing/phlebotomy in all practices
- Tendering
- Phlebotomy at The Royal London or Mile End Hospital
- Imaging at The Royal London or Mile End Hospital

Newham

- Near site testing/phlebotomy in some practices
- ELFT Phlebotomy at Appleby Health Centre, Vicarage Lane Health Centre, Shrewsbury Road Health Centre, Centre Manor Park
- Phlebotomy at NUH
- Tendering for direct access MRI and US
- Imaging at NUH
- Non-obstetric ultrasound in practices and community

There is no joint process across local clinical commissioning groups for reviewing the benefits from new technologies. Without this, adoption of new technologies is likely to continue being piecemeal, reducing the benefits and creating difficulties in providing 24/7 access and creating further inequality in access for local residents.

7 There is the opportunity to develop testing that is closer to patients' homes, minimising wasted time for patients and clinicians.

Patients have reported often having to travel long distances, perhaps for preoperative tests they could have had closer to home. These take up outpatient appointments and often involve repeat visits. The clinical working group saw the possibility for improvements for patients. The following points were crucial:

- Ensuring the quality of preoperative tests performed out of hospital
- Ensuring the right tests are being taken – in time for results to be reported
- Ensuring effective sharing of results across sites and organisations
- Ensuring continuity of care for the patient.

The clinical working group agreed the following principles for providing local access to diagnostics:

- Where local access has a clear benefit to patients (e.g. local when it involves fasting tests for older people; patient mobility; transport difficulties)
- Ease of local implementation of services
- Frequency of examinations (e.g. anticoagulation)
- Saving money
- The most effective use of a workforce with specialist skills
- Reducing waiting times
- More multidisciplinary involvement.

8 We can improve clinical decision making in primary care through clearer local diagnostic pathways.

Clinicians noted that some informal knowledge existed but there is no list of local diagnostic pathways or clear clinical guidelines on managing and using tests in primary care. Similarly, NICE guidelines exist on preoperative testing, but it is not clear if there are local acute protocols or if staff always actively apply them. So in some cases clinicians request extra tests without a clear need.

9 Performance could be improved further by ensuring we measure the things that matter to clinicians and patients.

Performance data from Barts Health suggests there is variation in turnaround times, particularly for high-volume disciplines such as haematology and clinical biochemistry. For example, turnaround times for electrolytes serum tests range from 73% of tests turned round within one hour at Whipps Cross Hospital to 29% of tests turned round within one hour at Newham Hospital. Some performance depends on operational issues, such as staffing in the specimen reception as well as request practice in A&E. Work is underway to improve this situation in Barts Health. However, there is room for improvement. We should aim to ensure that with increasing demand the trust can improve performance for all disciplines in the lab and in reporting, and across the whole pathway.

Systems are not set up to monitor the end-to-end pathway in imaging or pathology. In imaging, the request-to-report parts of the pathway are well monitored as they align with national targets. There is, however, no monitoring of whether reports have been sent to the referrer. These problems are worsened by variable IT systems and the use of manual processes.

10 We could improve care by developing effective methods of communicating with primary and community care on discharge.

Clinicians have told us that the discharge summaries are too complex and do not draw out the key changes in medication, which is what general practice needs to know. This results in difficulties in continuity of care and creates extra pressure on general practice regarding follow-up and medication reconciliation (the process of obtaining an up-to-date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes, deletions and additions).

Community pharmacists feel that improved communication between them and the hospital pharmacies could improve the quality of care for patients after discharge.

11 Pharmacists working in new ways can be vital in getting people home quicker.

Pharmacists told us they believe that the procedures for discharging patients and prescribing practices on discharge can be improved. Regarding the discharge of patients, prescribing their medication often begins only when the decision to discharge is made. This creates an instant delay and a wait for patients. There are some examples of good practice at Barts Health on this. For patients who stay longer than 48 hours, these include making medication requests on the day before discharge so it is ready for the patient to take away. This improves bed use and patients like it. We should see how we can do the same kind of thing for shorter-stay patients.

.....

In addition, we need to recognise the support that patients need on managing their medication on discharge from hospital. For patients who are newly diagnosed with a long-term condition, taking their medication as they should may be hard in the first 6–8 weeks. Nationally, medication errors contribute to 5–8 per cent of hospital admissions and readmissions, of which almost half are preventable¹⁰⁸. There needs to be good clinical support after discharge to improve outcomes and prevent patients being readmitted because of medication errors.

12 Community pharmacists could provide some care closer to home.

The clinical working group agreed there was an opportunity to expand the pharmacist's role to include enhanced services and provide care closer to home. The group saw potential for better pharmacy services across a range of patient need. Pharmacy services could become more visible, giving proactive care where it is most convenient for the patient. The Planned Care: Elective Surgery Clinical Working Group also recognise the opportunities to increase the community pharmacist's role in planning preoperative care assessment for less-complex patients.

The group mentioned the following as models that could benefit the whole system:

- Pharmacy first - a local initiative to promote pharmacies as the first port of call for minor ailments
.....
- Named pharmacist for people with long-term conditions
.....
- Health champions – a local initiative where pharmacy staff offer advice and information about healthy living
.....
- The provision of 24/7 community pharmacy services, particularly to support end-of-life care services.
.....

However, a key barrier to adopting potential new models of pharmacy, especially those regarding better services, is the fragmented commissioning of these services. Without a consistent, joined-up approach, these initiatives will remain time-bound projects and not become part of the seamless delivery of care.

13 We need to work hard to tackle local issues to ensure that IT is an enabler rather than a barrier to integrated care and enables new ways of working.

The clinical working group saw IT systems and technology as a key enabler for ensuring high-quality clinical support services. The group thought the way existing IT systems operated worsened performance. One of the major issues that needs to be tackled is the connectivity between sites and some manual operating systems that still exist.

Not all Barts Health sites use the same systems so there are compatibility problems between them. A work programme is underway to tackle this. But we need improvements to ensure we can measure the end-to-end pathway for both pathology and radiology. There also needs to be work to eliminate manual systems. Improving IT infrastructure is important too, as this will aid clinical support services in the community and connectivity with other providers.

108 HSJ 2012

14 The move to 24/7 services will bring with it further challenges for attracting and retaining the highest-calibre workforce for clinical support services.

Analysis of Barts Health workforce data shows that the Clinical Support Services Clinical Academic Group has the highest annualised voluntary turnover of all groups (16.7% compared to 12.8% trust average). However, of staff appointed in the last 12 months it has the second-lowest turnover of staff in the trust, suggesting this is an improving situation (7.3% compared to a trust average of 16.1%). One of the largest challenges facing the workforce is the move to seven-day services.

Emerging priorities and models of care

Based on the clinical working group's analysis, we set out below the main emerging priorities and models of care.

Understand and plan for the extra capacity and more effective ways of working required because of population growth and changing demand.

It is unclear whether there is enough capacity in local clinical support services to deal with the local population increase and disease profile. There is no long-term, shared plan across the east London NHS to deal with this. So that we can ensure local services can meet future demand, we need to do detailed capacity analysis and modelling. This must also take into account:

- potential efficiency gains from improved ways of working
- changes in technology and the effect on capacity and the tests required.
- a move to 24/7 services and the effect on capacity this may have
- potential reductions in over-investigation through local initiatives to reduce unsuitable use of technology.

If there is not enough capacity locally, we need to develop a local plan between providers and commissioners. This should also consider how such a service should work across sites.

Aligning hospital capacity with future models of care and developments in technology.

In future, planning groups looking at developing new services or reorganising existing services should include representatives from clinical support services. Then they will better understand the effects of change on clinical support services.

Tackling the over-use of tests and reducing the burden of unsuitable testing.

There is evidence of over-investigation originating from both hospital, community and primary care. To reduce this, we propose that a role be developed for clinical support services experts locally in demand management, development of evidence-based protocols, and systems to reduce inappropriate testing.

Similar findings have been identified by the Academy of Medical Royal Colleges (2014) which states that up to £221 million per year could be saved across the whole NHS by reducing unnecessary X-rays for lumbar spine or knee problems¹⁰⁹.

Equity of access: we have found variation in equity of access to high-quality services outside the acute trusts

To provide equity of access across north east London and benefit from economies of scale, we propose that:

- providers and commissioners cooperate to align the commissioning of clinical support service provision across boroughs where these services are inequitable
- there is detailed workforce planning to see whether we would be more efficient if we moved to 24/7 services across sites
- there is future collaboration with other clinical working groups to confirm which tests could be provided more efficiently in the community via technology or remote working
- a local 'route to market' process is developed to ensure we rapidly apply the latest technology in a way that is equitable across north east London.

To ensure value for money and that benefits are gained from adoption at scale, there should be a joint process across the clinical commissioning groups. This would review the potential benefits of new technologies and agree when these should be rolled out at scale across the boroughs.

We need clear and robust local pathways of care.

To move towards meeting the London Quality Standards, we need to take forward strategy work to ensure we embed robust network arrangements across sites. It is especially important to tackle capacity bottlenecks, for example in interventional radiology. We need to consider options for achieving this alongside the current set-up of maternity and emergency surgical provision.

"Could pharmacists talk to GPs more, to coordinate care?"
PPRG member

109 Association of Medical Royal Colleges (2014) 'Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care'

We need to tackle operational issues that affect our ability to provide high-quality and efficient services.

We need to resolve IT problems where these cause clinical risks and prevent new ways of working. Work should be done to reduce clinical risks across the current IT system and prioritise the clearing of blockages.

We need to develop oversight of the whole clinical pathway to enable effective management of bottlenecks and rapid clinical decision-making. To tackle this, we should work with commissioners to put in place suitable performance measures and standards for the whole pathway – while ensuring that the payment system rewards the right behaviours. There should also be further work, linked to actions already identified, to:

- support skill development
- embed local protocols
- tackle the effect of IT systems on clinical and quality-of-care issues.

We need to realise the potential in community pharmacy to improve the links between care settings and provide care closer to home.

Work is needed to develop a north east London strategy for pharmacy-enhanced services. This should bring together the NHS England area team, CCGs and the North East London Pharmaceutical Council. This work should try to tackle the fragmentation of the commissioning of extended pharmacy services so that pharmacy becomes a key provider and interface between other commissioned services.

**“Good principles in the Clinical Support Services section.
Demand is so high even now”**
Barts Health staff member

8 Do we use our resources in a sustainable way?

Our resources: summary

The NHS and local government face significant funding constraints, with growth in demand expected to rise more quickly than growth in funding over the next five years.

We need to work together to make better use of our resources so that we can improve patient experiences and invest in better care.

In particular we need to:

- make £434 million of quality and productivity savings over the next five years and get better at preventing ill health if we are to become financially sustainable
- improve communication and information sharing across different parts of the NHS and with our partners so patients can better care for themselves and do not have unnecessary appointments and tests
- make more effective use of technology to improve care and efficiency
- make better use of infrastructure and make choices about the best way to spend resources, for instance reducing our spending on more outdated, less-efficient buildings and support services so that we can invest more in modernising facilities and caring for people at home.



Case studies: We have recently invested in some excellent facilities

- A new acute assessment unit has recently opened at Whipps Cross Hospital as part of a £27m investment in emergency care
- Patients are benefiting from a £7m redevelopment of the A&E at Newham Hospital and £17.5m investment in the maternity unit
- A new Royal London hospital
- A world-class specialist cardiovascular centre at St Bartholomew's Hospital could save up to 1,000 lives a year
- The Sir Ludwig Guttmann Health Centre in the Olympic Park will provide state-of-the-art primary and community health facilities for the growing local population
- A £4m scheme at Homerton Hospital to refurbish the Clifden centre for sexual health and open the Jonathan Mann clinic for the treatment and support of people with HIV.

Finance and efficiency

NHS funding to commission health services is reducing in real terms

There are now three groups of services commissioned by the NHS, and each is facing real-term reductions in funding over the next few years.

NHS England commissions primary care services (GPs, pharmacists, dentists, optometrists)

There is a national efficiency requirement of 2.5%. The current allocation method is under review. Co-commissioning with CCGs is being considered. Current spending on GP contracts for Tower Hamlets, Newham and Waltham Forest is £118m (including associated costs). Primary care spending in east London is in the lowest 25% nationally

CCGs commission community, mental health and acute hospital care services

CCG funding varies from £1,151 per head in Tower Hamlets to £995 per head in Waltham Forest (2014/15). This will reduce in real terms over the next five years by an average of 11% across the three CCGs, meaning that the CCGs need to make £128m of savings

NHS England commissions specialised services (e.g. trauma, neurosurgery). About a third of services provided by Barts Health are specialised

NHS England aims to make at least 3% efficiency savings each year. There is a long-term problem as demand historically grows by 5% each year. A balanced budget for 2014/15 was only achieved nationally through a one-off payment

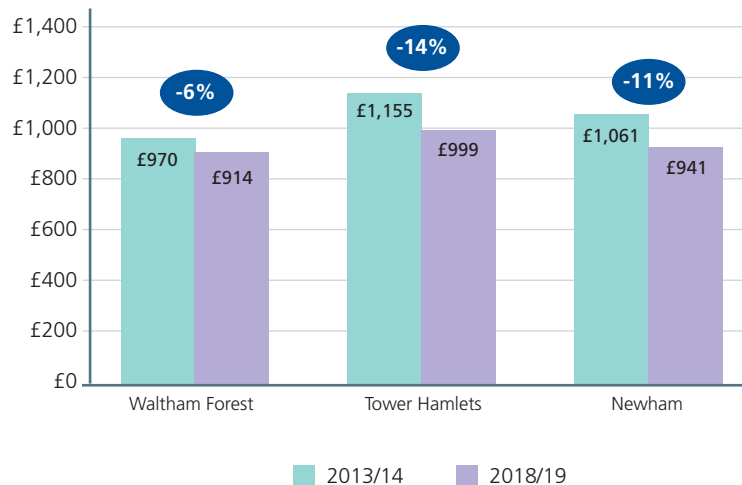
Local CCG allocations

The annual increase in funding coming into the economy will not keep up with the cost of increases in the underlying demand for health services caused by a growing population.

There is no funding for inflation, pay increases or other cost pressures. All increases in costs have to be met by efficiencies and cost reductions. Effectively the economy faces real-terms reductions in funding for the next five years. The graph on the next page shows the allocation per person to the three CCGs when adjusted for forecast inflation¹¹⁰.

¹¹⁰ Allocations as notified by NHS England. Health cost inflation assumptions: 2013/14 = 2.5%, 2014/15 = 2.5%, 2015/16 = 2.9%, 2016/17 = 4.4%, 2017/18 = 3.4%, 2018/19 = 3.3%

Real-terms reduction in per-capita allocations 2013/14 to 2018/19



Commissioners need to identify quality, improvement, prevention and productivity savings each year to contain the cost of increasing demand:

- **Tower Hamlets:** £27m of savings (net of new investments). Between 1.8% and 1.4% of turnover each year.
- **Newham:** £42m of savings (net of new investments). 2.5% of turnover each year.
- **Waltham Forest:** £47m of savings (net of new investments). Between 3.5% and 2.5% of turnover each year.

Providers

Local hospital, community and mental health providers all face significant financial difficulties. The prices they can charge for services have been held steady and have not kept up with inflation, pay rises or other cost pressures. Acute providers also face falls in income as a result of new models of primary and community care and commissioner savings plans, as these aim to reduce the number of patients using hospitals.

Projections of future income and costs show that local providers will need to make £434 million of savings over the next five years:

- **Barts Health:** £324 million of savings. (5.1% of turnover)
- **Homerton Hospital:** £54 million of savings. (3.8% of turnover)
- **East London Foundation Trust:** £56 million of savings (3.9% of turnover)

Barts Health in particular has a big difficulty with its underlying deficit of £47 million in 2014-15.

These challenges pre-date the Barts Health merger and were among the reasons for it. But as yet only a small part of the expected savings have been made.

Staff and the public gave us many examples of where our services are inefficient and wasteful

Typical of these were:

- Duplication of tests, prescriptions, taking patient histories etc
- Failure to maintain continuity of care when patients move from one step on a pathway to the next (e.g. discharges from hospital to community services)
- Appointments or operations cancelled at the last moment, often without explanation
- Poor procurement leading to higher prices than necessary
- Staff unsuitably skilled or trained to do the job

Many respondents felt low staffing levels contributed to inefficiency.

We need to work together to find ways to give better value

The efficiency of Barts Health compared to similar organisations shows there are opportunities to make savings and improve value for money. Of the £324 million savings needed, we estimate that about £200 million could come from productivity improvements and a further £38m from better recovery of income (although this will then present a cost pressure for commissioners). Examples of productivity improvements include:

- reducing length of stay
- reducing costs of clinical supplies
- standardising best practice pathways
- making better use of the staff we have
- better methods of measuring performance, leading to local improvements
- improving asset use
- improving our systems

These gains will require new ways of working and joint working between all partners in east London.

Better efficiency will not bring all the savings needed, so we will have to make savings in other ways such as setting up services differently and rationalising estates.

“We need to rebalance funding between acute and community care, to discharge elderly frail people from hospital and free up acute beds and reduce waiting times”

Dame Angela Watkinson, MP for Hornchurch and Upminster

- Barts Health has saved over £2 million in the last few years by cutting water use, recycling more and saving energy (a scheme that is set to save £400,000 a year and won the HSJ Energy Efficiencies Award)
- Homerton Hospital has saved money by retendering services, reducing reliance on agency staff and increasing productivity in theatres.

Better Information Technology is essential if we are to make efficiencies and improve patient care and experience

To achieve achieve this goal we need to improve basic information sharing and communications

- The NHS often communicates via paper (referral letters, requests for tests and tests results), even for urgent cases
- Patients still have to book consultations by phone or in person (creating extra work and delays), and attend consultations in person (meaning more use of the physical estate). We do not make best use of mobile technology, texting and emailing
- Our IT systems and infrastructure are not designed to support mobile management or remote care, which is very important in supporting the shift of care closer to the patient’s home
- Our systems need to be connected so we can enable our clinicians to communicate effectively across different organisations and different care settings
- Our information sharing with social services is fragmented. This causes delays, particularly in our care for elderly and vulnerable patients
- We need patients to have a ‘one portal view’ to enable their self-care and self-management – appointments, prescriptions, procedures etc recorded and accessible in one place.

We do not share information consistently or effectively

Patients are often seen by many staff working across many systems. Tests are duplicated and patients are asked for information many times. Patients have a right to expect that a single summary record should be sharable between NHS staff to ensure a joined-up service.

This is a challenge as:

- 1 The NHS has many information systems and platforms, leading to a fragmented view of a patient
- 2 These systems do not easily interact with one another
- 3 Inconsistent levels of information are recorded and shared
- 4 Information governance can be seen as a barrier to sharing information between services and organisations
- 5 Our clinicians have varied understanding and skills to use data available to them for clinical decision making.

We need to increase the use of NHS numbers to enable records to be linked and shared.

Our patients and the public have said....

We asked our patients and the public to give us feedback on the current challenges and opportunities that technology, or the lack of it, brings:

- Patients want us to give priority to improving the appointments system in hospital and primary care. They want to book appointments online
- Bring in technology to benefit patients. Make it simple, intuitive and seamless for users
- Patients want access to their records so they have tools to manage their own conditions and have better choice
- Services should always engage with patients and the public to re-design technology they will use.

“Patients and staff should have electronic access to their records and test results”

Female Waltham Forest resident, aged 41–65 (also a service user and NHS staff member)

“There needs to be a streamlined booking system across medical services”

Feedback from a Newham, Waltham Forest and Redbridge Healthwatch event

“Available technology has not yet been widely introduced to enable patients to be monitored remotely for a range of long-term conditions (e.g. COPD, diabetes), preferably by a named clinician(s) to enable continuity and confidence”

*Female Waltham Forest resident, aged 41–65
(also a service user and NHS staff member)*

Our clinicians and staff have said...

Our clinicians have highlighted to us specific IT and technology issues that prevent them providing the best possible care for their patients:

- We lack reliable access to patient records with up-to-date information from different services
- We need to sort out the basics through updating infrastructure and the effectiveness of systems
- The variation of IT systems used across and within healthcare organisations and the lack of effective interface between them means we do not have access to patient data when we need it most, particularly in emergencies or crises
- We need to eliminate manual records to create fully digitised patient records we can access in real time
- Technology needs to be enabling and support the shift of services from hospitals into the community
- Technology needs to support multidisciplinary team working by effective sharing of real-time information on patients
- We are not fully using technology to improve patient safety
- Technology needs to be used to improve access to services and enable patients to take better care of their own conditions.

We received consistent feedback from patients and clinicians that relates to future work:

- Engaging patients in technology and IT redesign so the solutions are developed with their benefit in mind
- Giving patients access to their care records will empower them to manage their own conditions.

Better use of technology can transform the way people access healthcare services, and support clinicians in decision-making and patients in managing their conditions

Technology brings great opportunities to change the way we work. It can help save money, give patients better access, provide better care, and improve patients' experience.

- The first UK operation to fit a wireless pacemaker took place at Barts Health last year
- Wireless foetal monitoring equipment is being used at Newham, giving women with higher-risk deliveries the choice of a water birth
- A team at Johns Hopkins University uses videoconferencing to give speech therapy to patients with a cleft palate in other countries.

Self-monitoring devices can empower patients in their self-care:

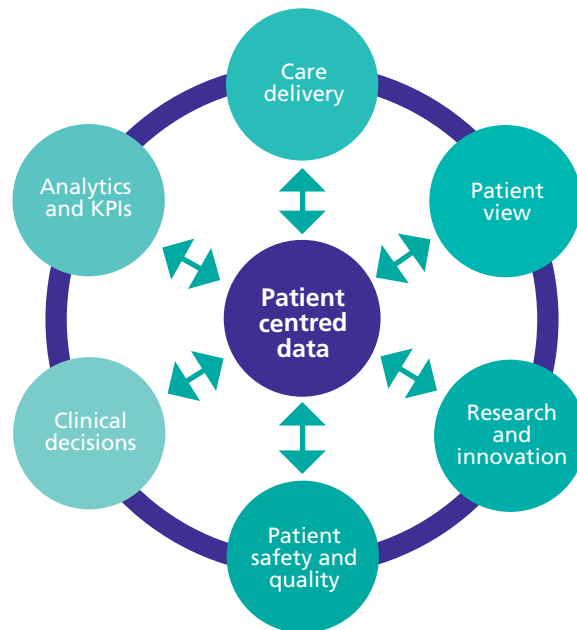
- For instance Myhealthlocker is an electronic personal health record for people using mental health services. Service users can collect, store, edit and manage their own health information, including their GP and hospital records, in one place. 'Rate my day' is an online tool to track sleep, anxiety and energy levels
- Practices in Tower Hamlets have been trialling a WebGP tool to help reduce the number of appointments for minor ailments by offering self-help on over a hundred common conditions that patients bring to their GPs. It includes a symptom-checker to ensure that only patients with ailments suitable for general practice attend an appointment. It directs others to different services such as pharmacies. It also contains a call-back facility from a 111 nurse 24/7 within an hour via a web form on the system.

We need to be ambitious in introducing and using technology for better patient outcomes.

By aiming to create patient-centred, timely, accurate and secure data that is linked to different components of our patient pathways, we can achieve efficiencies while improving patient experience and treatment.

The digitisation of healthcare data, linked to each patient in real time, is a unique opportunity to transform our push for individual and public health improvement. It will support clinicians in decision-making, freeing them to focus on patients' needs. It can transform patients' attitudes by prompting, directing and supporting them in managing their own health.

The benefits of patient-centred data



When improving our technology to give better patient outcomes:

- We need to take into account patients' and clinicians' needs – we need to wrap technology around services rather than the other way round
- We need real-time information for clinical decisions to be effective
- We need to change attitudes to using technology among clinicians, staff, patients and carers to maximise the benefits it brings
- We need to continually train our staff, particularly clinicians, in new technology. We could include technology training in the medical students' curriculum
- When introducing or designing new technologies we need to take our system's maturity into account – how it compares with what already exists and what skills the users already have
- We need to introduce incentives to encourage individual organisations to adopt new technology or a joined-up approach in commissioning it
- We should work with patients and carers to fully use and embed new systems, enabling self-care and self-management
- We need to work together to have a joined-up approach to technology and IT design, deployment and continuous innovation.

.....

Effective design and deployment of IT and technology is an important source and enabler of transforming our services.

A strategic WELC IT and Technology group, focused mainly on supporting the integrated care agenda, was set up in 2013. This group will become part of a programme to strengthen IT and technology cooperation among health and social care organisations serving our area.

The group will focus on:

- Identifying existing programmes of IT and technology work to maximise opportunities of cooperation and shared learning among partnering organisations
 - Developing and applying governance, consent and information-sharing arrangements among all partnering organisations
 - Encouraging progress by partnering organisations in fixing basic IT-related issues experienced by patients and staff – such as fast network connectivity, hardware and software infrastructure
 - Building on what has been achieved through the WELC Integrated Care Programme, develop an IT and Technology Strategy for east London that identifies:
 - principles for IT and technology cooperation in east London
 - areas of IT and technology where joint working and resource and approach sharing will be suitable and benefit patient care (such as developing an integrated patient portal)
 - principles for identifying joint commissioning opportunities for IT and technology
 - governance methods to apply the strategy.
 - Developing, applying and monitoring the delivery plan underpinning the IT and Technology Strategy
 - Developing stronger links with local authorities and health alliance organisations to align the initiatives across the system
 - Continually looking for new opportunities of joint working to maximise IT and technology resources and eliminate inefficiencies.
-

Summary of IT and technology issues discussed by the clinical working groups

The Maternity and Newborn CWG discussed the difficulties of providing care when IT and technology systems are not joined up across acute and community settings or across different areas of east London. There are examples of technology being used to increase patient benefits, such as wireless foetal monitoring equipment in Newham Hospital, which enables women with higher-risk deliveries to choose a water birth. Some of the opportunities have not yet been applied, such as improving discharges at Whipps Cross Hospital using technology-driven solutions.

The Children and Young People CWG focused its discussions on technology-enabled information sharing, which is an important way of effectively safeguarding children and young people. Robust information sharing would also support effective discharge and handover arrangements across different care settings.

The Long-Term Conditions CWG saw technology and IT systems as important ways of transforming and improving care. They could provide a central fully digitised patient record that clinicians in a range of settings and organisations could access. An electronic process of discharge and handover, particularly where there has been a change in medication, would increase patient safety and quality of care. Finally, the use of self-monitoring devices needs to be more widespread to empower patients to become experts in their own condition and its management.

The Unplanned Care CWG recognised that current technology does not provide a reliable oversight of demand across the health system. This makes the urgent care pathways less responsive. A fully digitised patient record would support effective triage of patients by 111 or at other 'entry points' for unplanned care benefitting the overall patient care and reducing the demand on A&E. The group has also discussed the huge opportunities for using mobile diagnostics to support unplanned care closer to home, particularly for nursing and care-home residents.

Planned Care – Elective Surgery CWG focused on the opportunities that new technology brings. Use of telephone consultations reduced face-to-face contacts by 50% and waiting times from 5.5 days to one day.

Clinical Support Services CWG discussed ways of improving current systems for clinicians to do their job more effectively and the opportunities for providing better patient care that new technologies can unlock. The lack of connectedness between systems and thus the ability to share information on diagnostic results are important barriers for clinicians. By stopping paper referrals and using voice-recognition recording across all sites and care settings, we could improve care quality and the effectiveness of clinical services. The group also discussed the need to use technology to enable staff to see the entire patient care pathway and the provision of services in the community.

The local NHS estate

We rely too much on estates and facilities that we do not use effectively

Because our work is based on physical and paper interactions, we spend a lot of our money on estate (buildings) that we don't use effectively. Money spent on inefficient estate could be spent on improving care.

The ownership and occupancy of buildings used by the NHS to provide services has become increasingly complex. This makes it difficult to track all the assets used by the NHS and know their cost, condition and usage. To plan the local health economy strategically, we will need to build and keep better records of the assets.

Quality of the community and primary care estate: There are about 150 GP practices and 70 community premises in east London, costing an estimated £90 million a year to maintain. Some of these facilities are poor and not fit for providing modern healthcare. Extended working hours and new technologies could reduce the number of premises we need; and bringing services together into fewer, larger premises could help us give better care at less cost.

Full use of the best-quality estate: A large part of the estate is new (or newly reconditioned). We need to make sure it is fully used. For example, much of the Sir Ludwig Guttmann Health Centre in the Olympic Park is empty, but it will be more fully used as the area's population grows. Space at The Royal London and Newham hospitals and a number of health centres could also be better used.

Whipps Cross Hospital: The most important estates issue in secondary care is the Whipps Cross site. Much of it is more than a century old, in a poor state of repair and not suitable as a place for healthcare in the 21st century. Barts Health and the CCGs agree that the site must be redeveloped and modernised. The plans need to be based on a strong clinical strategy for east London.

What we heard from staff and public

The condition of some estate was criticised, particularly some primary-care estate. Staff and public gave examples of buildings and infrastructure that were not suitable for modern healthcare.

There was disappointment that staff accommodation had been lost in the last few decades. People felt this made recruitment and retention more difficult. Some said that providers should actively promote the development of key-worker housing.

Many respondents mentioned NHS buildings that had been empty for long periods and said more should be done to use them.

How the findings in the *Case for Change* are likely to affect the NHS estate

A strategic estates planning group, which involves all the commissioners and providers across east London, has considered how the estate needs to alter so it can respond to the changing demands of health services.

- The population growth will create new demand for health services. In some instances this will require new facilities, in others extra space will need to be released from existing buildings. A specific example is maternity services where the Maternity and Newborn Care Clinical Working Group has found that there need to be more delivery rooms in maternity departments for the rising birth-rate.
- There is concern about some of the poor-quality estate, the variation in its condition and a recognition that it needs to be improved.
- We expect that many of the future proposals to develop clinical services will require estate work before they can be applied. This might include making facilities at one unit larger so that services on many sites can be brought together, or it might involve investment in community buildings so that hospital services can be moved out to a community setting.
- As relationships with local authorities build and services become more integrated, there may be opportunities for shared use of council and NHS facilities. This was highlighted as particularly important by the Children and Young People Clinical Working Group.
- Some productivity gains will need capital investment. For example, old hospital wards are often expensive and inefficient because staffing levels need to be higher and the hospital has limited flexibility in how beds can be used.
- Developing key-worker housing could help us resolve workforce difficulties.
- New technologies, such as new methods of diagnosis, may also require changes to the estate.
- There will need to be savings from better use of the estate. In some instances savings can be achieved through better use of the current assets:
 - Identifying premises (buildings or parts of them) that are vacant and using or making money from them
 - Making better use of premises that are only used for parts of a week or a day
 - Extending the use of premises into evenings and weekends

Savings could be made by moving services and disposing of sites when they become redundant.

Priorities for developing the NHS estate

The strategic estates planning group will be included in an overall programme to strengthen estates planning in east London. Thereafter it will oversee an estates strategy for the area. The priorities for this group will be:

- Build and maintain a comprehensive asset database of all the different estate assets owned and used by the NHS. The database will include information about their condition, use and cost.
- Using this analysis to develop a strategic plan for providing new and improved estate. This should identify:
 - where investment is needed to respond to increasing demand, changing health provision and poor-quality estate
 - how efficiency can be improved by disposing of some assets and using others better
 - how to respond to the service changes that the next phases will identify
- Investigate partnering with housing associations with a view to improving opportunities for staff housing
- Develop stronger links with local authorities to identify where there can be shared arrangements.

The strategic estates planning group will become part of the overall programme to strengthen IT and technology cooperation among health and social-care organisations.

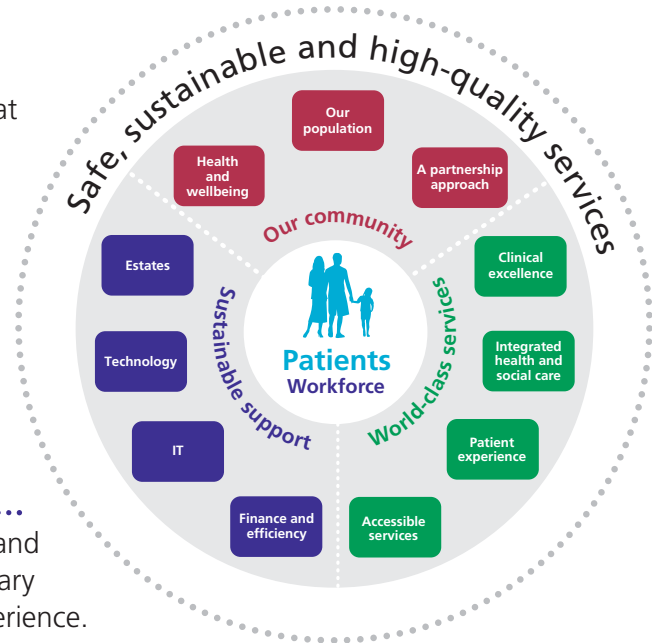
We will use this analysis to develop a strategic plan for providing new and improved estate, where needed. We will engage with all key stakeholders, including local planning authorities, to plan new health provision that meets NHS requirements within the new planning and development framework.

9 How sustainable is our workforce?

Summary

We have several examples of leading-edge schemes that will help build a sustainable, flexible, professional and engaged workforce. But we also need to tackle several important workforce difficulties if we are to reduce health inequalities and improve the health of people in east London.

- Most of our workforce was trained to support a hospital-based model of healthcare. But this model is not suitable or efficient for the growing number of elderly people with mental and physical illnesses.
- We urgently need to tackle difficulties in attracting and recruiting skilled staff for specific posts in both primary and secondary care, which reflects the national experience.
- The nature of healthcare is changing, with a major shift to a mainly community-based, multidisciplinary way of working that is tailored to seven-day-a-week services.
- We need to develop staff who have flexible mindsets and transferable competencies. These will include strong teamworking, technology-enabled continuous improvement skills and the ability to effectively support self-management of patients. These competencies need to develop against a backdrop of continuous investment in maintaining a balance between the generalist and specialist professional skills of individual staff members.
- Our workforce will be increasingly working across health and social care. We need to consider integrating roles while supporting our workforce in making this transition.



Resolving these challenges will require strong and well-supported leaders at all levels of organisations as they will be crucial in engaging local teams and nurturing a culture of compassion.

There are additional issues in east London, in particular the high cost of living and housing shortages. We need to work closely with local authorities because recruiting a local workforce is essential to providing suitable and sustainable care. We need to:

- tackle the current difficulties and workforce gaps
- ensure our workforce have the skills they need to provide the models of care in the future
- ensure our workforce is engaged, flexible and motivated to be able to provide high-quality patient care and innovate to support continuous service improvements
- recognise the importance of distributed and collective leadership in pushing for improvement across professional boundaries.

Patients and the public have said...

We asked our patients and the public to give us feedback on the current workforce difficulties and opportunities. It can be summarised in three key areas:

Current resourcing levels

- Staff seem to be stretched and overloaded so we need to consider more carefully the number who have the right skills to provide high-quality services.
- Keeping our staff for a long time (high retention) should become one of our goals because this helps with continuity of care and retains valuable knowledge about patients and services.

Supporting and developing our workforce

- Staff need to be suitably trained and supported in their ongoing development to provide the best possible care. In particular, our need to improve overall customer care and communication skills emerged as a significant training need at all levels and across different professions.
- Staff morale needs to be improved. We recognise the link between high staff motivation and their ability to provide high-quality care.
- Our workforce needs to be more flexible, with working patterns that align with periods when services need to be provided, including weekends, to meet patients' needs.
- It is essential that staff performance is actively managed.

Leadership

- Managers need to empower staff at all levels to lead the services and introduce changes that will give better patient care.
- People said managerial roles do not improve patient care and there needs to be more investment in clinical roles.

"Workforce is key"
Redbridge Health Overview
and Scrutiny Committee

Clinicians and staff have said...

Our clinicians have highlighted specific workforce problems. We have grouped them into three main areas:

- **Recognising and resolving current workforce problems that are a barrier to providing best patient care now**
 - In some areas posts remain unfilled due to local or national shortages of skills.
 - Our staff retention needs to improve, which will help us reduce our use of bank and agency staff.
 - In some areas staffing levels are not suitably matched to the needs of the service.
 - In some areas the skill mix of staff for each service does not match the needs of the service and patients.
- **Our current workforce set-up does not support future models of care**
 - Our workforce is one of the key enablers of our shift to seven-day services.
 - Our workforce models need to underpin our improvement drive, which aims to reduce the variation of care and care-quality gaps.
 - Our workforce models need to enable us to have multidisciplinary team working across different acute services and care settings.
 - We must build a flexible workforce model that aligns with the changing demand for the service. This will be supported by staff members doing the work on varied rotas across different sites.
- **Training and development for current and future service needs**
 - To ensure flexibility, we need to focus on maintaining a broad spectrum of clinical skills in increasingly specialised clinical areas.
 - There is a need to re-focus and improve primary-care training and development to ensure it matches current and future service needs.
 - There must be an improvement in secondary-care training and development, to support the move away from the paternalistic model of care, with the emphasis on self-management by patients.

There are significant similarities in the feedback we received from both patients and clinicians and some of these issues are already being addressed by primary and secondary care providers in east London.

Barts Health has set a target of 95% permanent staff by December 2015. Initiatives to meet this include Saturday assessment days and overseas recruitment for hard-to-fill nursing posts

Homerton Hospital is developing a clinical leadership programme that aims to strengthen the staff's ability and effectiveness in multidisciplinary teams

Primary care organisations want to adopt the role of 'physician associates' to support the work of clinicians in multidisciplinary teams

**"Key worker
accommodation is very
important"**

*Waltham Forest Health and
Wellbeing Board)*

Case studies: we have some excellent workforce models

Barts Health is a major employer. Nearly 40% of staff live in east London and the trust is increasing its recruitment of local people by:

- direct and reserved access to entry-level jobs for people who are unemployed in east London
- job readiness assessment and support
- apprenticeships which lead to permanent jobs. Between April and December 2013, 75 candidates were placed. As well as apprentices in theatre support, pharmacy, administrative and laboratories, new roles will be created in maintenance. There will be a pilot scheme for healthcare assistant roles in outpatient departments.

Barts Health has moved from the traditional idea of vacancy rates to focusing on 'fill rates'. This involves forecasting recruitment needs over the year, based on turnover (both leavers and internal moves/promotions), predicted service changes and staffing pressures such as maternity leave. Approval to recruit is done in bulk, contributing to a more efficient process. This has enabled the trust to reduce its time taken to fill vacancies (e.g. date of instruction of the vacancy to unconditional offer of employment) from 18 to eight weeks. Patients benefit from improved quality and continuity of care as reliance on agency/bank staff reduces.

At Homerton Hospital, 83% of staff agree that 'Care of patients/service users is my organisation's top priority'. This is against a national average of 68%.

The Barts Health *Community Works for Health* programme seeks to recruit a culturally and linguistically sensitive workforce. This improves patient care and helps the trust's understanding of, and response to, the needs of patients.

Tower Hamlets uses an innovative network system. These bring together GP practices to work collectively to manage long-term conditions and other services with shared incentives and outcome measures. The networks have developed a more cohesive primary care community. These have reduced variation in quality, for example in diabetes care and childhood immunisation.

“We see NHS staff leaving the UK to go and work abroad. We think that there is more opportunity for the careers in the NHS to be promoted to young people in schools. There should be more open days, and apprenticeships”

Young Adviser, London Borough of Waltham Forest (aged 15–21)

We have gaps in the existing hospital workforce

The existing staff structure doesn't enable us to always provide a high-quality service.

- Adult emergency surgery: we do not meet requirements for all emergency admissions to be seen and assessed by a relevant consultant within 12 hours
- Emergency admissions: for fractured neck of femur, no Barts Health site ensures all patients are seen and assessed by a consultant orthopaedic surgeon within 12 hours
- Antenatal and postnatal care: the need for a closer attention to women's mental health during antenatal and postnatal care is not reflected in workforce models and professional skills training
- Children and young people: there are too few acute staff with suitable skills and expertise to meet patient needs while complying with the European Working Time Directive – particularly in consultant and staff specialty and associate specialist grade
- Even where the staff structure may be suitable, we sometimes cannot fill the posts. Despite a range of initiatives to recruit and to retain staff, some posts are hard to fill and some areas have national and local shortages. It is particularly hard to recruit:
 - A&E consultants
 - Paediatric nurses
 - Nurses
 - Midwives
 - Health visitors
 - Theatre staff
 - Geriatricians
 - Biomedical services
 - Consultant obstetricians
 - Generalist medical consultants

“The focus of the NHS must be to provide quality, efficient services delivered by highly skilled and motivated staff”

Female Waltham Forest resident, aged 41–65 (also a service user and NHS staff member)

For consultant roles, these difficulties are worsened by increased specialisation of medical training, resulting in reduced flexibility among our workforce.

We have to focus our efforts on recruiting high-calibre staff. But we also need to improve our retention levels so we can achieve a healthy workforce level without relying too much on bank or agency staff.

In addition, our nursing workforce is ageing and we need to attract new recruits. In 2011 12.4% of the UK's nursing workforce was aged 55 and over, with 48.6% of midwives eligible to retire in the next 10 years. Overall, The King's Fund predicts that by 2021 there could be a shortage of 40,000 to 100,000 nurses in the UK.

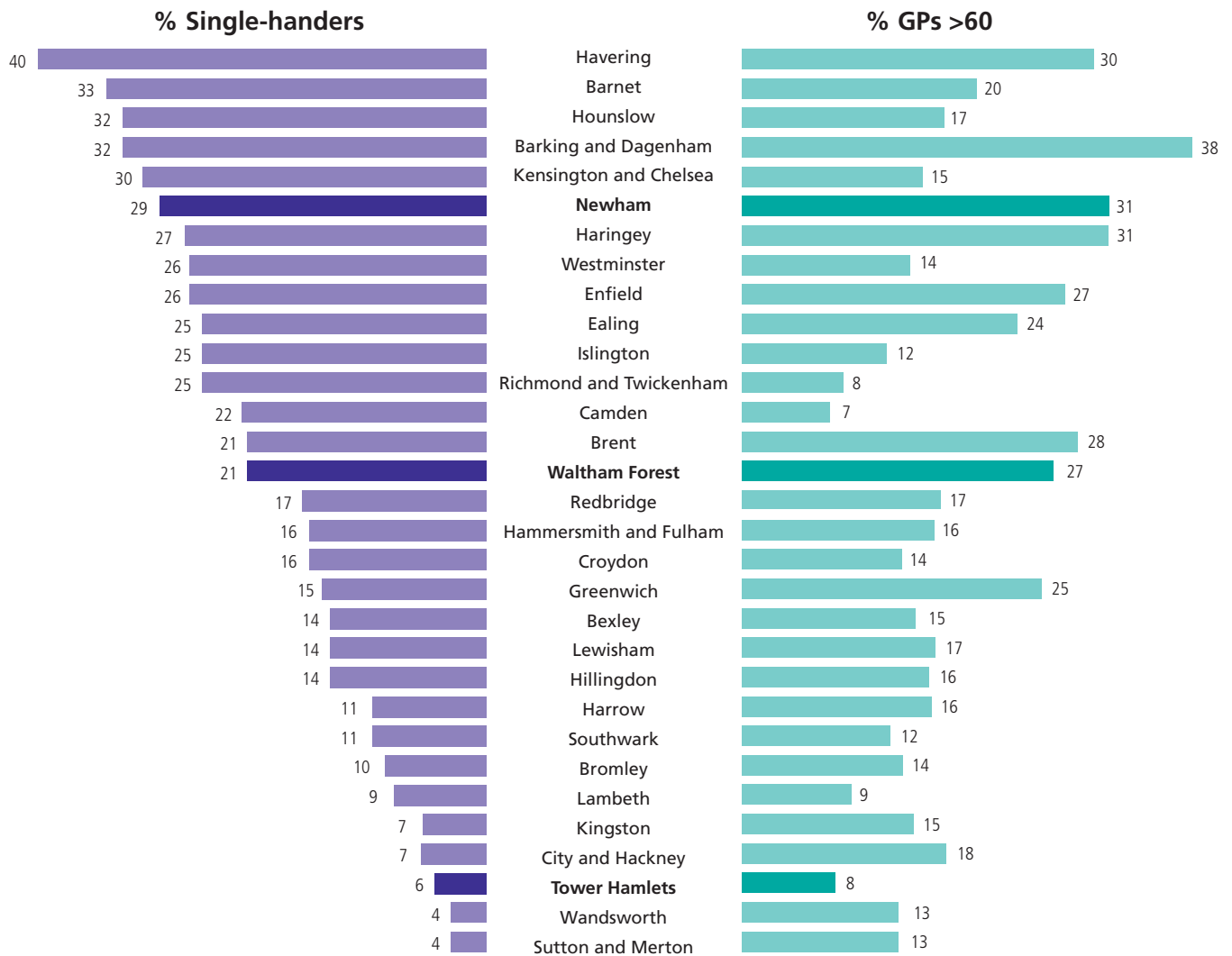
We need to continuously support staff in fulfilling their potential and ensure they are as productive as possible. Our current performance management practices need to be clearer and more consistent to give effective support to members of staff whose performance is below standard.

We have existing gaps in the primary care workforce

- We have great difficulty recruiting practice nurses and district nurses. This will get worse because this workforce has an older age profile – meaning that a significant number are nearing retirement. The situation is worsened by the fact that the profession is not seen as attractive to newly qualifying nurses. Last year there was a 40% decline nationally in those choosing to enter the profession.
- In particular, we have found a need for more specialist skills to support primary care and community pharmacy in prescribing and medicines management. We could increase our provision of care closer to patients' homes if we shifted resources from acute pharmacies to community pharmacies.
- There are important clinical skills/training gaps. Only 31% of the capital's GPs believe they have received enough 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. This is worsened by variable access to specialist clinical advice and second opinion across London, resulting in higher referral rates to secondary care.
- The wider primary care workforce is not used effectively. A north central and east London primary care workforce project, working with the local education and training board, found that some important ways to tackle this would mean a greater focus on:
 - team working across professional boundaries
 - fostering innovation through education
 - developing new roles in navigation skills and support
 - the development of practice nurses
 - improving healthcare support workers training
 - community pharmacy development.

■ There is a shortage of GPs. By 2021 the country will need 16,000 more GPs than there are now. Tower Hamlets and Newham already have some of the worst GP-to-patient ratios in the country¹¹¹. It is an ageing workforce. In London 17% of GPs are over 60 compared to 10% nationally, and many areas depend on single-handed GP practices.

Kings fund (2012): Percentage of single handers and GPs over 60 in London

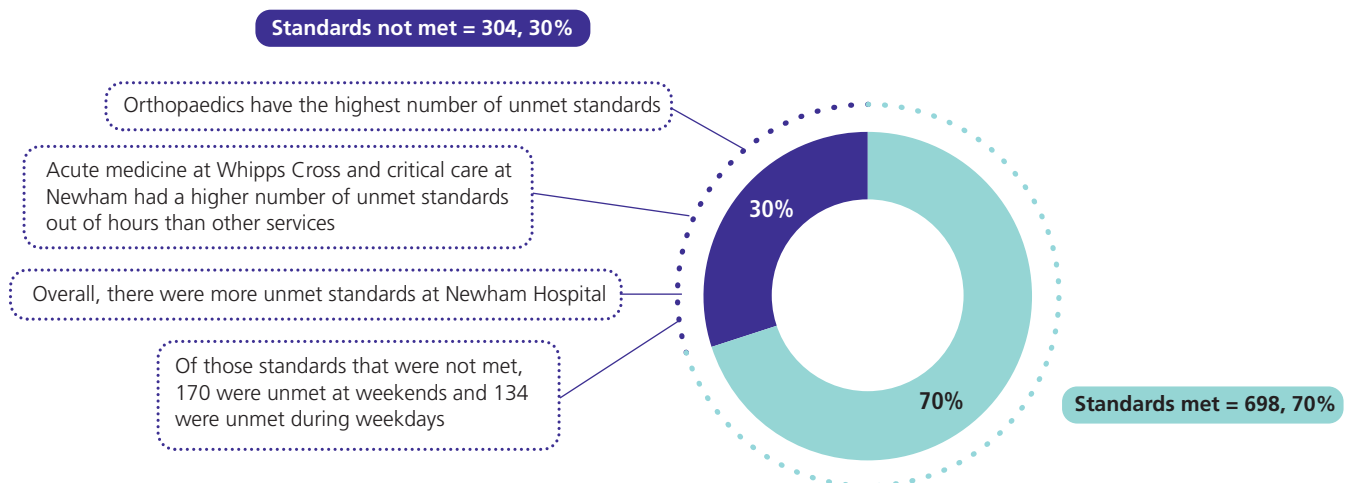


111 Centre for Workforce Intelligence (2012)

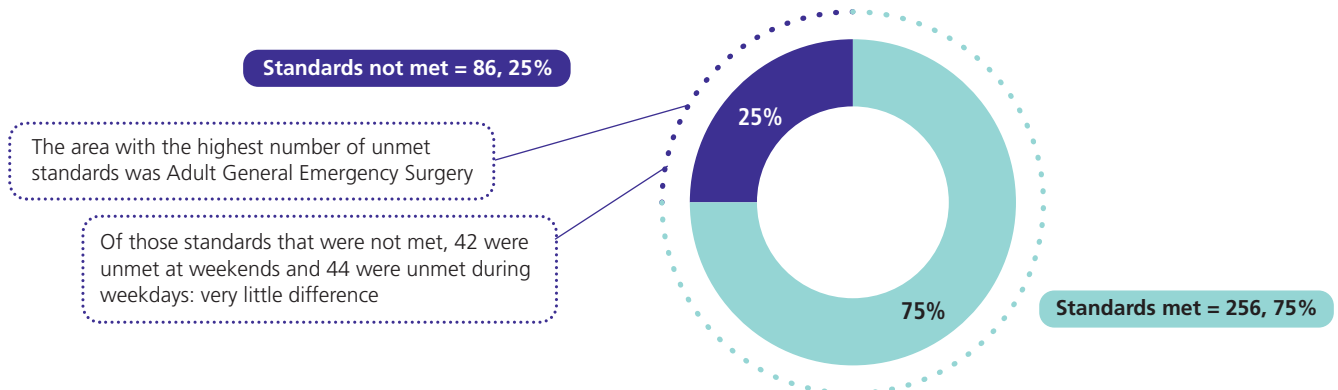
Our workforce does not support new models of care: London Quality Standards

- Clinical experts and patient panels have developed evidence-based quality standards for each service area. Complying with the London Quality Standards is not compulsory, but assessment against them does show some important workforce difficulties
- The London Quality Standards have been an important way of moving towards seven-day services and significant changes to working patterns on how we manage emergency and planned care clinical responsibilities
- Self-assessments at Barts Health and Homerton Hospital show several unmet London Quality Standards on weekdays and at weekends.

Barts Health self-assessment (2013)



Homerton self-assessment (2013)



Our workforce needs to be better engaged and motivated

■ An engaged and motivated workforce is essential. Trusts with higher levels of staff engagement are generally rated by the Care Quality Commission¹¹² as outperforming other trusts. They have:

- better-quality services
- more robust finances
- higher patient satisfaction scores
- lower staff absenteeism
- consistently lower patient death rates

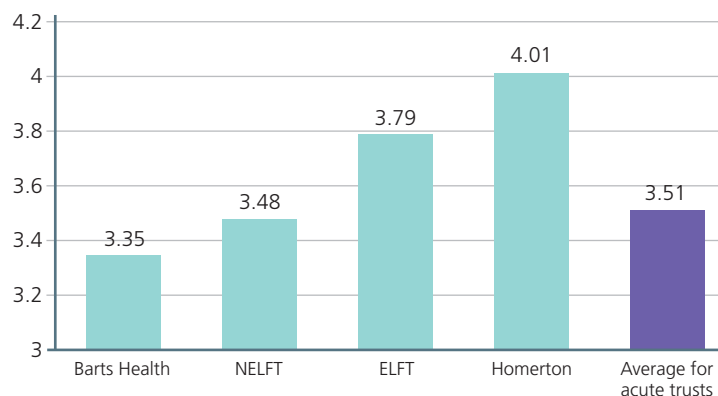
■ The Care Quality Commission¹¹² stated that staff feel disconnected from Barts Health's executive leadership team, undervalued and unsupported. They reported low morale at all staffing levels and some staff felt bullied. In their 2013 NHS Staff Survey, Barts Health scored in the lowest 20% nationally for overall staff engagement and staff recommending the trust as a place to work or receive treatment. However, staff do believe their role makes a difference to patients

Barts Health measures staff engagement. The results in March 2014 showed significant variation across Clinical Academic Groups (CAGs), with engagement ranging from 56% of staff in women's health to 33% in clinical support services.

The women's and children's CAG has identified issues of culture and behaviour. There is a programme underway, *Great Expectations*, which tackles the level of bullying and harassment that staff in this CAG report (47%).

In primary care, Newham Clinical Commissioning Group has reported challenges in attracting and retaining GPs, nurses and practice managers.

Staff recommendation of the trust as a place to work or receive treatment (score out of five, aggregated from three questions in NHS staff survey 2013)



112 Care Quality Commission (January 2014): CQC Inspection Report

Meeting the challenges of the future will require new ways of working, new roles and new skills underpinned by innovative training and development initiatives.

The health and social care demand has undergone a radical change and east London needs a workforce ready to meet patient and public needs in the 21st century.

It will be difficult to provide a named clinician in primary care.

The Department of Health is consulting on its proposal for a named clinician, which is where a single point of contact is provided to coordinate the care of vulnerable older people. This policy is likely to have a significant impact on general practice. It will mean thinking differently about how we develop the rest of the workforce (practice nurses, healthcare assistants and community teams).

Our current skill mix and training are not necessarily suitable. We should start giving more importance to models of training that equip healthcare staff with transferable competencies.

We should regularly align workforce skills to service needs. Barts Health do this through a corporate and clinical advisory group annual strategic planning process. For adult and specialist services, this resulted in extending the role of community nurses and introducing a newly commissioned role of care co-ordinator.

We need to focus more on education and training of staff – both formal (e.g. courses) and informal (e.g. staff rotations)

Future models of care suggest a need to change the skill mix of the workforce. This is driven by:

- increased delivery of care in a community setting
- integrated care
- the introduction of seven-day services.

For example, the Academy of Royal Colleges has suggested a need for the role of a more generalist consultant physician, who can do ward rounds and agree patient discharges at weekends and out of hours. This may affect how we train healthcare staff and the commissioning of education. This will be particularly important to providing integrated care, creating roles that can cut across professional and organisational boundaries.

**“Educating and
developing staff is crucial
in delivering change”**
Barts Health staff member

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Increased flexibility will also be a key skill of the future clinical workforce. We are likely to see clinicians travelling to give care in a community setting or providing alternatives to face-to-face care for patients, enabled by technological development. We need to model our workforce based on the needs of services, which will be increasingly providing care all days of the week.

We need more care provided by multidisciplinary teams that can provide the right type of care in a setting that meets patients' needs. The success of this new way of working will depend on staff flexibility in the roles they can perform. It will require a shift in organisations' approach to workforce recruitment, training and continuous professional development.

Without this shift, we will continue having difficulty recruiting to posts that work from multiple locations or in the community. Candidates regard these as less attractive options.

There are national shortages and ageing workforce profiles in some professions, particularly in primary care. So we need to be more creative about how we use our workforce. We need to adopt more roles such as physician associates or care navigators. They will support services with the aid of staff with most suitable skills.

All future changes will require our workforce to adopt technical and behaviour changes. Then patients will see a major change in their care.

No single organisation can effectively overcome the workforce difficulties described here. So a strategic workforce group has been set up to work cooperatively on resolving them across east London. The group includes all key workforce stakeholders. It will become part of an overall programme to strengthen workforce arrangements in health and social care organisations that serve our area.

After the discussions at the first group meeting, we have outlined the main priorities as:

■ Forming and applying a plan to increase the number of staff joining the caring professions across different settings. We will achieve this by:

- connecting with schools and universities to promote the professions and NHS jobs to people in education
- creating a brand and communications aimed at informing the public about the variety of roles available at different entry points
- linking with organisations supporting 'back to practice' schemes to align these with any promotional activities

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■ Improving career development opportunities for caring professionals by linking social and health care career paths

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■ Exploring opportunities brought by working together to reduce the reliance on bank and agency staff which will drive the efficiencies across the system

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- Focusing on creating innovative new roles that will help us tackle workforce shortages and enable us to work across professional and organisational boundaries
 - Develop a shared and evidence-based understanding on what skills and competencies we need our workforce to have in order to provide our services and the best possible care; use this analysis to design new roles needed in the workforce with a plan to provide the transformation
 - Develop and invest in care navigators and healthcare assistants to support more joined-up care for our patients
 - Exploiting opportunities for joint working and sharing resources in education and training, particularly in:
 - Statutory and mandatory training
 - Leadership training
 - Cross-organisational training
 - Maximising the effect of work currently done by the Community Education Providers Network.

The group identified the main enablers for the above streams of work:

- Patients' perceptions and mindsets need to change so that they recognise the best care can come from a range of professionals, not just doctors
- Embedding NHS values to release and empower our staff to provide compassionate and joined-up care
- Investing in training of current and future staff to increase levels of competence, flexibility and generalist professional skills
- Creating new ranks in existing and future workforce structures to enable new recruits to join the workforce at different entry points, including through volunteering.

The group agreed that the following approach to their joint initiatives will help achieve their common goals:

- Including patient and staff voice and representation in any future workforce initiatives. This will ensure they are shaped with their feedback and experiences in mind
- Continuous sharing of information on opportunities for joint working and collaboration, with a long-term planning view, will help make the system more efficient.

These priorities will be discussed with a wider group of stakeholders. We will form and agree a joint working plan, along with timescales and resources.

Workforce issues discussed by the clinical working groups (CWGs)

Each of the CWGs considered workforce issues as integral to their ability to provide excellent patient care. The summary below captures some specific workforce themes that each CWG highlighted.

The Maternity and Newborn CWG discussed specific workforce issues regarding the area's population growth. There could be 5,800 more births by 2020 so we need to focus particularly on ensuring suitable staffing levels against the backdrop of recruitment difficulties and an ageing workforce, particularly in midwifery. We need to reconsider our workforce models so that we take into account the emerging trends of rising use of intensive-care cots, other high-dependency activity and falling special-care activity. There is a higher prevalence of mental illness in north east London so our workforce needs to be suitably skilled to pay close attention to women during ante and postnatal care.

The Children and Young People CWG considered training-related issues in primary and secondary care. The current trend of training specialisation does not enable us to take a holistic approach to patients, particularly on their mental health needs. Moreover, the primary care and community workforce has historically had limited paediatric training. This, combined with limited time for observation during 10-minute appointment slots in GP practices, results in higher levels of referrals to secondary care. Any shift of activity into the community will be hard to achieve if we do not provide suitable training and access to specialist clinical advice and second opinion across east London.

The Long-Term Conditions CWG studied the effects of the lack of seven-day services in community and social care services, which results in the acute trusts' limited ability to discharge patients over the weekend. This is worsened by a lack of acute physicians such as generalist medical consultants, which results from the increased specialisation of medical training. On the other hand, the group saw that the primary care workforce was stretched and needed support and training to help patients manage their long-term conditions without referring them to secondary care. Some excellent workforce models underpin integrated care such as multidisciplinary team working in areas such as diabetes care. But they need to be expanded beyond specific care pathways and have consistent mental health and social care inputs. The move towards integrated care has already created a need for a different type of skill in existing roles. It will continue driving the need for new posts such as care navigators. We need to ensure that we support our current and future workforce to respond to these changes.

The Unplanned Care CWG echoed the concerns of the Long-Term Conditions CWG over the lack of seven-day services in community and social care services, which resulted in their limited ability to discharge patients over the weekends. The group discussed the difficulty of recruiting to certain posts such as A&E consultants, qualified critical care staff, theatre nurses and general surgeons. The group reflected on how this increased the use of bank and temporary staff to fill the gaps. The group also emphasised the correlation between the shortage of GPs and district nurses and increased demand for A&E and other urgent-care services. In addition, the group said lengthy medical training was a significant difficulty because it affects the speed we can apply changes.

Planned Care – Elective Surgery CWG reflected on the increasing specialisation of the profession and the growing number of sub-specialists. These staff are seeing fewer cases because of new alternative treatment options, meaning that patients do not need surgery. Some sub-specialties do not get enough patients to maintain their specialist skill set. Also, some that attract higher numbers of patients such as day-case surgery are not currently seen as an attractive career option. These trends result in a workforce model that is not well matched with service and population needs. As with the difficulties over unplanned care, the pace of change we want to see is affected by the length of medical training. We also need to use the existing workforce better and break down barriers in using primary care, particularly the community pharmacy workforce in postoperative care. This would be possible if we provided the right training.

Clinical Support Services CWG discussed the effect of rising population on the demand for their services and the need for an increased workforce in dealing with them. They considered this against a backdrop of observed shortages and the difficulty of recruiting to biomedical services posts, particularly pathology. We need to expand multidisciplinary team working and reflect this in staff rotas so that a team consisting of a radiologist, a radiographer and nurses could work across the network. The group recognised the key role that technology will continue to play in the skills and development of their staff.

10 The change required and next steps

The *Transforming Services, Changing Lives* programme identifies several areas where there is a case for change to secure high-quality care in a sustainable way. Patients, residents and clinicians from across east London have made it clear what is needed to achieve these changes in hospital care. And this is nothing short of the whole health and social care system – primary and community care, mental health, hospitals and social care – coming together to work across organisational boundaries to create lasting improvements for patients.

Many of these changes can take place quickly, while others will need further thought. Our programme outlines where we plan to transform services over the next two to three years to meet our future challenges.

Eight areas of consensus are:

1 Our population is growing and the local NHS needs to respond to increased demand, for example in maternity and children's services

We expect 270,000 more people to be living in our three boroughs over the next 20 years; equivalent to one new borough. Rather than build a new hospital for this huge population growth, we plan to transform the use and effectiveness of our current health system and estate.

However, some areas of care will need to be expanded if the local health system is going to provide high-quality care in a sustainable way. Demand for maternity and children's services is expected to increase because of our rising birth rate, with up to 5,000 more births expected over the next ten years and 16,000 more children living in the three boroughs over the next five.

Detailed analysis is needed over the coming months to identify which maternity services will need to grow and where children's services will need to change. We need to develop different models of care to ensure hospital-based services can cope with extra demand. For example, clinical leaders in hospital and community children's services are working together to design better urgent and integrated care.

We are considering how best to take forward work in these areas through, for example, a strengthened maternity network for the whole of north east London involving commissioners, providers, service users and a children's network.

2 We need to care better for the rising number of people with long-term conditions

The highest proportional increase in population is expected to be among over-65s, who can expect to live longer but suffer more long-term conditions that need more complex care. We therefore need to improve and strengthen our integrated care approach.

We will need to do detailed capacity and demand modelling in the coming months to understand where and how services need to change, and the effect of this on support services such as diagnostic testing. By redesigning the way services work and by providing improved primary and community care through better care planning, we can ensure that more of our ageing population have the support they need to stay healthy and out of hospital until the end of their lives.

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An example of how we can change things is the way we are reviewing outpatient services at Barts Health to make them more responsive. Remote monitoring and Skype clinics can sometimes be more effective ways of giving ongoing care to patients with long-term conditions.

This work will continue under the WELC Integrated Care Collaborative, which is already ensuring those with multiple long-term conditions receive better care planning.

3 We and our partners need to work together more closely to strengthen our prevention approaches, supporting people to live healthier lives and improving physical and mental wellbeing

We know that our population's health can be improved: too many people die early from preventable diseases and too many people do not get the mental health support they need, early enough. Everyone has a responsibility for this. The NHS, local councils, health and wellbeing boards, businesses, schools, patients and the public need to work together better. We have heard that the NHS is not currently set up to give enough support to people to help them lead healthier lives. And we do not provide as much support for mental wellbeing as we do for physical health. Through workforce development, service redesign and working closely with colleagues in public health, we need to embed a prevention approach. This will mean working in partnership with patients to support them with their health and ensuring that all our clinical staff feel better able to support patients with their mental health.

We are already working together to try to increase the prevention work that takes place in our schools. The aim is to stop children and young people getting long-term conditions such as diabetes. However, we need to do more to ensure our approaches are co-ordinated, widespread and as effective as they can be.

4 The local NHS needs to invest time and effort in tackling inefficiencies. Estates, IT systems and care pathways sometimes do not work for the greatest benefit of patients or staff

Commissioners, local authorities and primary care services need to support local providers to save £434 million over the next five years. Given this, hospitals need to ensure they do not waste resources by working inefficiently. For example, administration should not cause patients to be notified of appointments too late. Operations should never be cancelled without good reason. And clinicians should not need to conduct duplicate tests because information has not been shared.

Local services need to work more quickly to fix the basics in poor administration. Different parts of health and social care need to work together to develop effective ways of sharing care records. This needs to be done in a secure way, so patients feel assured that their health records are held securely by services they trust. Work to improve IT and enable data sharing will be taken forward by the WELC IT and Technology Group.

Resources are also wasted through underused estates. We will work to make full use of our high-quality estate so we can dispose of or redevelop poorer-quality buildings. An example of this is that Barts Health is relocating services from the old London Chest Hospital site into a new purpose-built development at St Bartholomew's. This will help provide world-class specialist care.

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We endorse the London Health Commission's call to reform the rules on trust asset disposal, as this will enable receipts from local disposals to contribute both to solving our underlying financial challenge and would provide investment¹¹³. This would facilitate the provision of higher-quality and more effective and efficient care, both in and out of hospital settings. An example of how this would help is in modernising the Whipps Cross site.

Finally, discussions have highlighted several areas where transforming care pathways may provide quality-of-care and efficiency improvements. For example, on average, patients with dementia stay up to six times longer in hospital. Improvements in hospital and in out-of-hospital care settings could enable those with dementia to receive more suitable care in the best possible setting. Local providers and commissioners have also done good work to redesign pathways for patients needing neuro-rehabilitation. This means these patients face fewer delays. Further work is needed in the coming months to identify all the specific pathways in which it would be valuable to work together.

5 We need to fix our urgent-care system, ensuring patients are seen in the right care setting for their needs

Every year, thousands of patients in north east London are cared for by A&E departments when they could have received more suitable care closer to home. We also know that local A&E services are facing ever-rising demand and will need to respond to changes in provision elsewhere, such as the closure of King George's A&E department in Ilford. So there is an urgent need to progress work that ensures more patients get care in the right setting for their needs.

Local services need to develop models of urgent care that have consistent standards, are easy to navigate and are co-ordinated effectively between acute, 111, primary care and pharmacy services. These changes will take into account the recommendations in the Sir Bruce Keogh Urgent and Emergency Care Review. We also need to build on the work we are already doing to explore effective ways of giving rapid access to care for patients who need diagnostics and treatment without a hospital stay.

We then need to do detailed capacity and demand analysis and review the benefits and constraints of local provision in each borough. After that, we can consider options for improvement.

6 We need a transformed workforce for 21st-century care – with different skills and roles, working in different settings

Meeting the challenges of the future will require new ways of working. The London Health Commission calls for new hybrid health and social-care worker roles to be explored, defined and commissioned, and ultimately for staff to be trained. Ensuring patients are treated in a care setting suited to their needs will require more clinical staff to work across organisational boundaries. It will also require staff such as care navigators to support patients so that they get joined-up care. In addition, if staff are to achieve the programme's ambitions, they will need to be trained to better recognise disease-prevention opportunities

113 London Health Commission (2014): *Better Health for London*, p87

and give mental health support when needed. This will enable the population to be healthier and ensure mental health has parity of esteem with physical health. The programme has brought together providers and partners to form an East London Strategic Workforce Group. We recommend that the work identified in this document and other emerging findings are taken forward together, through this forum.

7 Changes will need to be made to local services if they are to be safe and sustainable. More services need to be provided in the community, closer to people's homes

The programme has shown that change is likely to be needed in emergency care co-ordination, elective surgery and outpatient provision. In outpatients, this means rapidly expanding areas of good practice, such as providing Skype and telephone consultations to patients. It also means stopping some practices that add little value to patient care and inconvenience patients by making them travel unnecessarily to hospital sites. In other areas, care needs to be provided close to home, where possible, and in specialist centres where appropriate. We need to learn from examples such as the arthroplasty centre at Newham Hospital. This has ensured that patients who undergo joint replacements have their recovery phase planned beforehand, allowing them to recover at home with better support.

Further work needs to be done to develop options. As part of this, we need to complete detailed workforce audits and capacity and demand modelling. However, each site will need to maintain core surgical services to meet growing maternity and emergency demand. But there may be an opportunity to provide more world-class services by developing centres of excellence for some specialties and improving the management of emergency and planned care flows.

8 The local NHS and partners will need to work together to secure high-quality and financially sustainable services in east London

One of the key findings of the *Case for Change* is that hospitals cannot secure high-quality and financially sustainable services on their own. If our programme of reform is to succeed, clinical leaders across primary, community and hospital services will need to continue working together with commissioners and local authority partners. An example of the success that cooperation can bring is Barts Health meeting its waiting-time target for A&E last year. This arose from a huge programme of cooperation across primary care, community services, ambulance services and Barts Health sites.



Transforming Services Together, our Five-year Strategy and next steps

Because organisations need to work together to create change across the whole health care system, the work to redesign hospital based care will go forward through a five-year strategy programme called *Transforming Services Together*.

Newham, Tower Hamlets and Waltham Forest CCGs have produced a *Five-year Strategy* that sets out how organisations will work in partnership to:

- help patients to be in control of their own health so they lead longer and healthier lives
- provide more co-ordinated health, social and mental health care
- improve hospital services and primary care services, including GPs
- ensure our budget is spent in the best way to provide a more sustainable health service

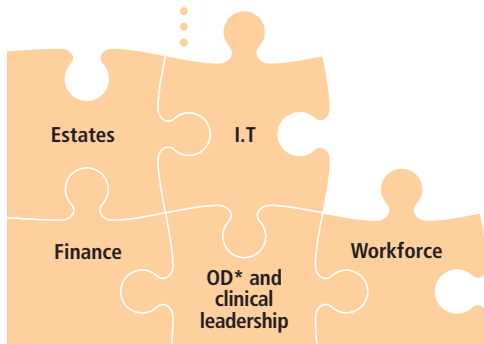
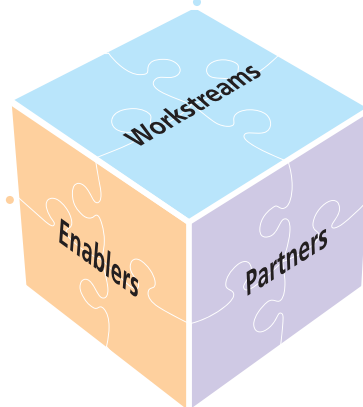
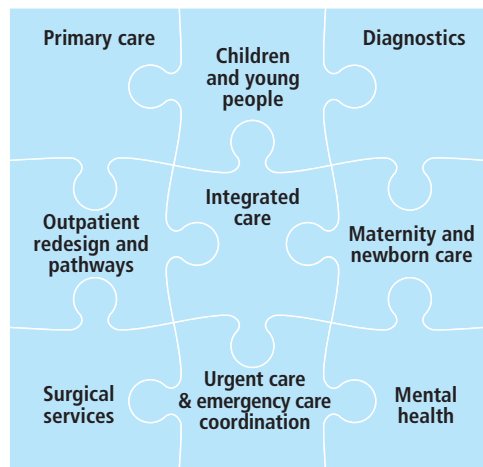
The findings of *Transforming Services, Changing Lives* will form the basis of work to improve hospital-based services through the relevant workstreams and enablers of the *Transforming Services Together* programme.

The next stage of our work is to understand more precisely where and how services and care models need to change for each patient group. This will then develop into more detailed proposals that we can fully understand how these and existing plans help tackle the financial difficulties. Over the next few months we will continue to engage with key stakeholders, the public and patients to develop our strategies.

We feel strongly that this *Case for Change* provides the basis for higher-quality, more efficient and joined-up care in east London. Continuing this work will mean that the whole health and social care system will work together better to improve the health of the population and secure high-quality sustainable services for staff, patients and taxpayers.

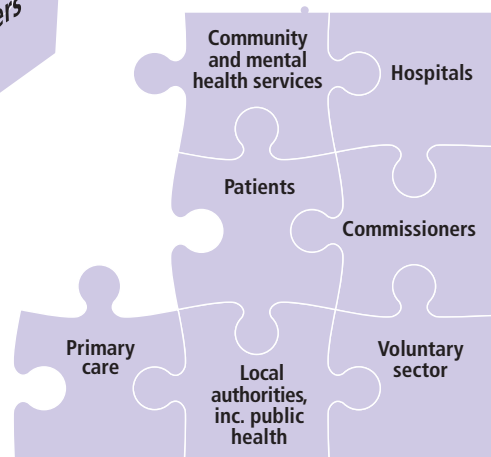
Transforming Services Together programme

Workstreams



*Organisational development

Enablers



Partners

Glossary

Word/acronym	Definition
A&E	Accident and Emergency department
acute care	Urgent care, normally in a hospital for a short period of time
ambulatory care	A patient-focused service where some conditions may be treated without the need for a stay in hospital
annualised	Calculated for, or as if for, a year
antenatal	Before birth; during pregnancy
alongside midwifery-led unit	Birthing unit where the care is given by midwives with an emphasis on natural deliveries without doctors' interventions. The unit is situated near to an obstetric-led unit. Also known as a co-located midwifery-led unit
Any Qualified Provider (AQP)	Way of commissioning in which any provider that can provide a specific service and meet the required minimum standards can be listed as a possible provider. Patients choose which provider on the AQP list they wish to see. No provider is guaranteed any work or the exclusive right to provide a service
bariatric service	Treatment of obesity or care of obese patients
best practice tariff	Additional payment available to NHS providers for certain treatments that meet enhanced or best practice standards
CCG	Clinical commissioning group. The organisations responsible for commissioning many NHS-funded services under the Health and Social Care Act 2012. In London, they are almost all geographically aligned to London boroughs
commissioning	Process of planning, agreeing and monitoring health services
competency	Ability to do something well or effectively
clinical academic group (CAG)	In Barts Health NHS Trust, CAGs are responsible for the management of services within their remit. They are headed by a senior leadership team which includes a group director (a doctor or a therapist); a director of nursing (or therapies) and governance; a director of operations; and a director of research and education
clinically-led	Plans and decisions being informed by people with a medical background, such as GPs, consultants and nurses
clinician	Health professional, such as a doctor, who treats patients – rather than, for instance, one who does clinical research
community setting	Care provided outside a hospital, in the local community
COPD	Chronic obstructive pulmonary disease; the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease

Word/acronym	Definition
condition-specific model	In this document, this means GP practices being paid for the care for specific conditions. If a patient has multiple long-term conditions, each condition is considered separately for payment purposes
demographic	Relating to population statistics, such as births, deaths and ethnicity
deprivation	Lack of material benefits considered to be basic needs in a society
disinvestment	Halting or removing investment in a programme
elective	Operations, procedures or treatments that are planned rather than carried out in an emergency
economies of scale	Economic efficiencies that result from carrying out a process on a larger scale
evidence base	Information used to inform, develop and agree a strategy or plan
GP	General practitioner
haematology	Branch of medical science concerned with diseases of the blood and blood-forming tissues
hyper-acute stroke care	Care provided to patients in a HASU
hyper-acute stroke unit (HASU)	Specialised unit that provides the immediate response to a stroke. This includes rapid assessment, early treatment (including clot-busting drugs if needed) and 24/7 monitoring
infrastructure	Basic structure of an organisation or system
intrapartum	Childbirth/delivery
IT	Information technology
model of care	Way of designing and delivering healthcare services
neonatal	Newborn babies, especially in the first week of life and up to four weeks old
neonatology	Branch of medicine concerned with the development and healthcare of newborn babies
neuro-rehabilitation	Care intended to help someone maximise their independence and function after an injury or illness affecting their brain/nervous system
obstetrics	Branch of medicine concerned with childbirth and the treatment of women before and after childbirth
obstetric-led unit	Hospital ward where women give birth and the care is given by a range of clinical staff, including midwives, anaesthetists and obstetricians
perinatal	Occurring in the time from about three months before to one month after birth

Word/acronym	Definition
phlebotomy	Taking blood
postnatal	Occurring after childbirth
primary care	GP practices, dental practices community pharmacies and high-street optometrists. Primary care is many people's first point of contact with the NHS
prevalence	Amount of disease in a defined population at a single point in time
procurement	Buying or obtaining goods or services
prognosis	Forecast about the course or outcome of an illness
Qualities and Outcomes Framework (QOF)	Voluntary yearly reward and incentive programme for all GP surgeries in England. It rewards GP practices for giving quality care and helps to fund further improvements in the delivery of clinical care
real time	Relating to computer systems that update information at the same rate as they receive it, enabling them to direct or control a process
referral	When a patient is sent from one part of the NHS to another part for assessment or treatment. Usually this is from a GP to a hospital, but referrals can also be made between hospitals, and within a hospital (from one department to another)
renal	Relating to the kidneys
SHLAA	Strategic Housing Land Availability Assessment – a technical document that helps identify a supply of potentially suitable sites for housing
secondary care	Services provided by medical specialists usually based in a hospital or clinic rather than in the community. Patients are usually referred to secondary care by a primary care provider such as a GP
specialism	A branch of medicine or surgery, such as obstetrics or paediatrics
specialty	A branch of medicine or surgery in which a doctor specialises, such as obstetrics or paediatrics
sustainable	Able to be maintained at a certain rate or level
tertiary care	More specialised health care for patients with complex conditions. Often provided by specialised hospitals or departments
triage	System that sorts medical cases in order of urgency to decide how quickly patients receive treatment, for instance in A&E
UCC	Urgent care centre

The appendices to this document can be found on www.transformingservices.org.uk

Appendices:

- Maternity and Newborn Care Clinical Working Group report
.....
- Children and Young People Clinical Working Group report
.....
- Long-Term Conditions Clinical Working Group report
.....
- Unplanned Care Clinical Working Group report
.....
- Planned Care: Elective Surgery Clinical Working Group report
.....
- Clinical Support Services Clinical Working Group report
.....
- Report of Engagement
.....

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