INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

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

Thursday, 17 November 2016 at 6.30 p.m.

C1, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

This meeting is open to the public to attend.

Members		**Representing**
Chair:	Councillor Clare Harrisson	INEL JHOSC Representative for Tower Hamlets Council
Vice-Chair:	Councillor Susan Masters	INEL JHOSC Representative for Newham Council
Councillor Ann Munn		INEL JHOSC Representative for Hackney Council
Councillor Ben Hayhurst		INEL JHOSC Representative for Hackney Council
Councillor Anthony McAlmont		INEL JHOSC Representative for Newham Council
Councilman Wendy Mead		INEL JHOSC Representative for City of London
Councillor Sabina Akhtar		INEL JHOSC Representative for Tower Hamlets Council
Councillor Muhammad Ansar Mustaquim		INEL JHOSC Representative for Tower Hamlets Council
Councillor James Beckles		INEL JHOSC Representative for Newham Council
Councillor Clare Potter		INEL JHOSC Representative for Hackney Council
Co-opted Members		**Representing**
Deputies		

The quorum for this body is the presence of a member from each of three of the four participating authorities.

Contact for further enquiries:
Daniel Kerr, Strategy, Policy and Performance Officer,
Tel: 0207 364 6310
E-mail: daniel.kerr@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

Scan this code for electronic agenda:

PARTICIPATING LOCAL AUTHORITIES

PAGE NUMBER

MAP OF LOCATION

PAGE NUMBER

1. APOLOGIES FOR ABSENCE

To receive any apologies for absence.

2. DECLARATIONS OF INTEREST

Any Member of the Committee or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

3. MINUTES FROM THE PREVIOUS MEETING

To agree the minutes of the meeting held on 7th November 2016. **TO FOLLOW**

4. TRANSFORMING SERVICES TOGETHER - REPORT TO THE INNER NORTH EAST LONDON JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (Pages 5 - 56)

5. ANY OTHER BUSINESS

Date of the next Meeting:
The next meeting of the Committee will be held on Tuesday, 13 December 2016 in the To be confirmed, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2BG

Inner North East London

Joint Health Overview and Scrutiny Committee (INEL JHOSC)

Membership 2016-17

The Committee comprises 3 members each from Hackney, Newham and Tower Hamlets and 1 member from the City of London.

Borough	**Members**
Hackney	Cllr Ann Munn (L)
	Cllr Ben Hayhurst (L)
	Cllr Clare Potter (L)
Newham	Cllr Susan Masters (L)
	Cllr Anthony McAlmont (L)
	Cllr James Beckles (L)
Tower Hamlets	Cllr Clare Harrisson (L)
	Cllr Sabina Akhtar (L)
	Cllr Muhammad Ansar Mustaquim (I)
City	Common Councilman Wendy Mead OBE (I)

L=Labour; I- Independent

Only named substitutes are allowed to substitute for a Member should there be a vote. One named substitute has been notified:

City of London: Revd. Dr Martin Dudley

The London Borough of Waltham Forest is a Member of the Outer North East London JHOSC but their Scrutiny Chair(s) are also invited to attend INEL meetings, as observers, when there are items of mutual interest.

The officer contacts are:

Hackney: Jarlath O'Connell jarlath.oconnell@hackney.gov.uk
Tower Hamlets: Daniel Kerr Daniel.kerr@towerhamlets.gov.uk
Newham: Michael Carr Michael.carr@newham.gov.uk
City: Neal Hounsell Neal.hounsell@cityoflondon.gov.uk

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Travel to Tower Hamlets Town Hall Offices

By Bus

The site has excellent bus links which connect it to East and Central London and beyond.

The 277 bus route begins and ends at the site, and the 15 begins and ends a 3 minute walk away at Blackwall Station. There are a number of other bus stops close by.

Most local bus services are listed overleaf and shown on the map, with the closest bus stops clearly marked on the enlarged map below.

By DLR and Tube

East India and Blackwall DLR Stations are in the immediate vicinity of the Town Hall site, with many other DLR stations within a short walk.

The closest Tube stations are Canning Town or Canary Wharf (both Jubilee Line).

For further information visit www.tfl.gov.uk/journeyplanner

By Foot

An approximate 20 minute walk from the site is shown by the blue circle (on the map overleaf). Many DLR and both Tube stations are within this zone.

There is pedestrian access to the site from all directions, allowing good access to the surrounding area.

For more information on walking in Tower Hamlets see www.towerhamlets.gov.uk/walking

For walking directions see www.walkit.com

HEALTHY BOROUGH PROGRAMME

tower hamlets becoming a healthy borough

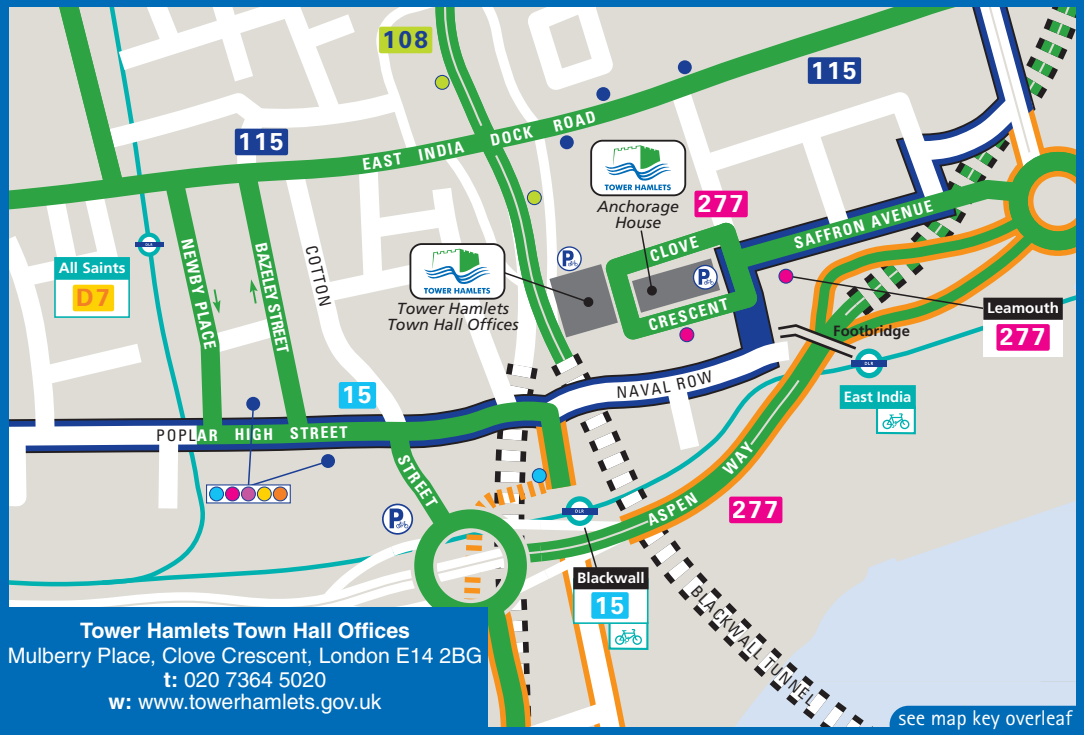
change 4 life

This map has been funded as part of the Tower Hamlets Council Travel Plan which aims to boost the number of staff and visitors travelling to the site by sustainable modes of transport.

Tower Hamlets is one of 9 areas designated as a 'Healthy Town' and has been awarded Government funding to tackle the environmental causes of overweight and obesity. Active Travel (cycling and walking) plays a major role in the programme.

www.towerhamletshealthyborough.co.uk

Design, digital cartography and print by Pindar www.pindar.com 03.10



Tower Hamlets Town Hall Offices
Mulberry Place, Clove Crescent, London E14 2BG
t: 020 7364 5020
w: www.towerhamlets.gov.uk

By Bike

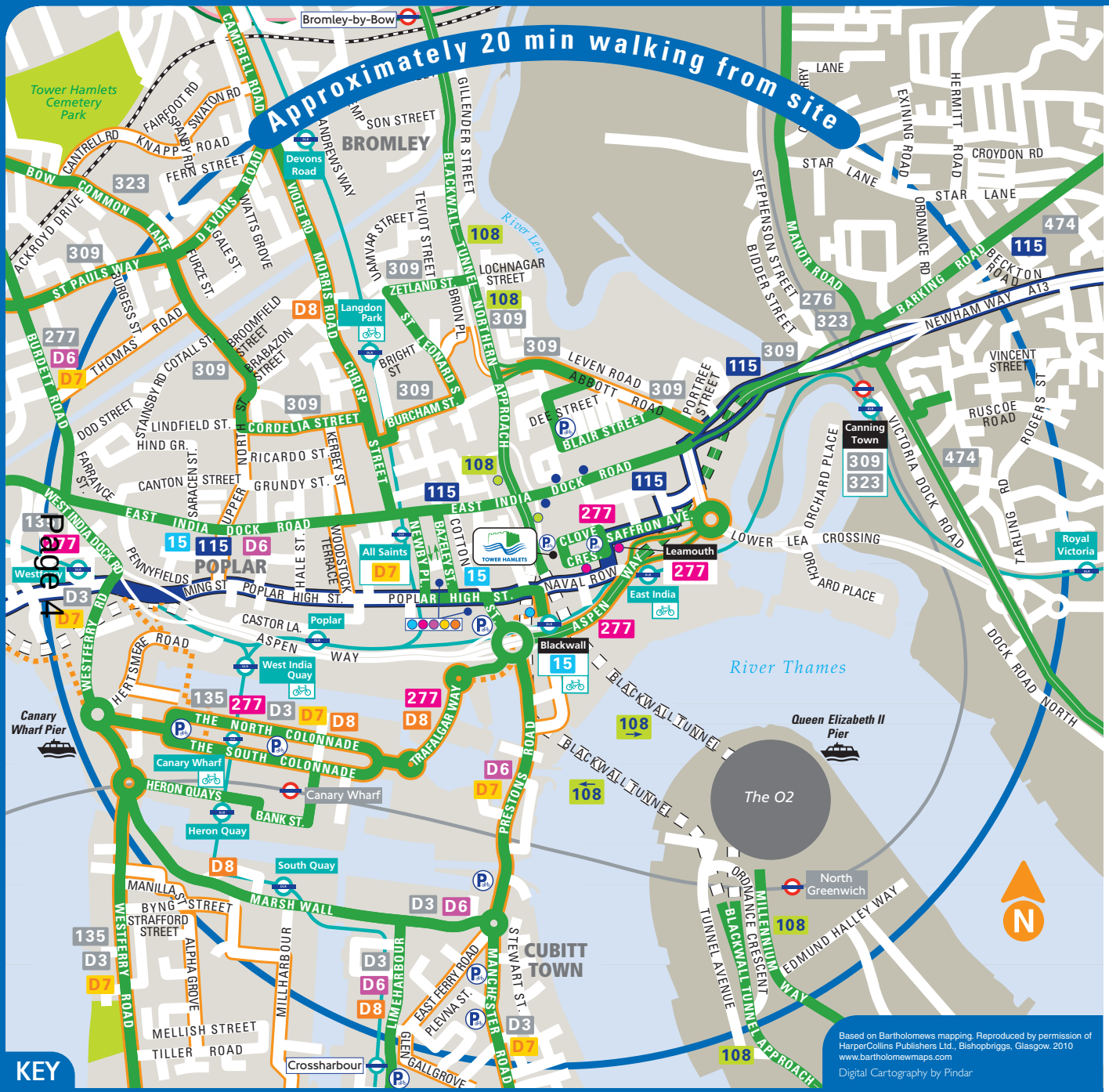
The site is well served by cycle routes, including Cycle Superhighway route 3 opening in 2010.

Cycle parking facilities for visitors are provided at ground level – see map (left).

Extensive cycling facilities are also available for staff who wish to cycle to work; email cycling@towerhamlets.gov.uk for details.

Further information on planning your journey by bike can be found at www.tflgov.uk/cyclejourneyplanner or visit www.towerhamlets.gov.uk/cycling for more information.

Map ▸▸▸



Bus Frequencies

15 Blackwall - Paddington Basin — Daily

Blackwall DLR - All Saints DLR - Limehouse DLR - Aldgate - Fleet Street - Charing Cross - Oxford Circus - Paddington - Paddington Basin

Monday - Friday daytime 6-10 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 6-10 minutes

Operated by East London

108 Lewisham - Stratford — 24 Hour

Lewisham DLR - North Greenwich - Blackwall Tunnel - Bromley-by-Bow - Stratford DLR

Monday - Friday daytime 8-10 minutes. Saturday daytime 10-14 minutes. Evenings and Sundays 20 minutes.

Operated by London General

115 East Ham - Aldgate — Daily

East Ham - Upton Park - Plaistow - Canning Town DLR - All Saints DLR - Limehouse DLR - Aldgate

Monday - Friday daytime 5-9 minutes. Saturday daytime 8-12 minutes. Evenings and Sundays 10-12 minutes.

Operated by East London

277 Leamouth - Highbury — 24 Hour

Leamouth - Canary Wharf DLR - Westferry DLR - Mile End - Hackney Central - Highbury & Islington

Monday - Friday daytime 5-8 minutes. Saturday daytime 6-10 minutes. Evenings and Sundays 9-12 minutes.

Operated by East London

D6 Hackney - Crossharbour — Daily

Hackney Central - Cambridge Heath - Bethnal Green - Mile End - All Saints DLR - Crossharbour DLR - Crossharbour ASDA

Monday - Friday daytime 6-10 minutes. Saturday daytime 7-11 minutes. Evenings and Sundays 15 minutes.

Operated by First

D7 All Saints - Mile End — Daily

All Saints DLR - Island Gardens DLR - Canary Wharf DLR - Westferry DLR - Mile End

Monday - Friday daytime 8-12 minutes. Saturday daytime 7-10 minutes. Evenings and Sundays 15 minutes.

Operated by First

D8 Crossharbour - Stratford — Daily

Crossharbour - Canary Wharf DLR - All Saints DLR - Bow Church DLR - Stratford DLR

Monday - Friday daytime 9-13 minutes. Saturday daytime 11-12 minutes. Evenings and Sundays 20 minutes.

Operated by First

For further information call 020 7222 1234 or visit www.tfl.gov.uk

Inner North East London Joint Health Overview and Scrutiny Committee 17th November 2016 **Transforming Services Together (TST)**	Item No **4**

OUTLINE

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

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

The INEL meeting on the 7th November looked at the financial implications of TST, and the modelling of the future primary care workforce.

This report and its accompanying summary include items covering:

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

ACTION

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

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Transforming Services Together

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

17 November 2016

Contents

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

1. Self-care

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

- Part 2, Chapter 3.1. Helping people manage their health better
- Part 2, Chapter 3.5. Cross cutting themes
- Part 3, Chapter 1. Expanded integrated care
- Part 3, Chapter 2. An integrated care model
- Part 3, Chapter 3. Improved end of life care
- Part 3. Chapter 4. Improving access, capacity and coordination in primary care

1.1 Introduction

The Transforming Services Together (TST) programme aims to deliver the following outcomes, integral to which are self-care strategies:

Improved patient experience
- A more enabling, person-centred experience of care, including more choice and greater satisfaction
- Better support to people with long-term health problems so they can manage their illness

Improved health outcomes
- Reduction in long-term conditions e.g. diabetes, by implementation of self-care services
- Improvement in health and fitness

Improved system efficiencies
- Demand management including prevention and delayed escalation to higher support or service needs

This paper seeks to provide an update to the Inner North East London (INEL) Joint Health Overview and Scrutiny Committee (JHOSC), highlighting current and planned self-care activity associated with TST workstreams, in the context of the NEL STP, and support from the Healthy London Partnership (HLP) Prevention and Self-Care programme.

The *NHS Five Year Forward View* set out a central ambition for the NHS to become better at helping people to manage their own health. The Department of Health estimated that £584million could be saved nationally (£96.1million in London) if self-care was prioritised[1]. Evidence from the Expert Patients Programme[2] suggests that for patients with long-term conditions up to £1,800 could be saved per patient and *Securing our Future*[3] suggests that for every £100 spent on self-care, approximately £150 worth of benefits are delivered. NHS Planning Guidance[4] therefore commits to patient activation, self-care and the major

[1] Healthy London Partnership, *Personalisation and Self Care: Case for Change* April 2016 www.myhealth.london.nhs.uk/system/files/Case%20for%20Change%20Summary%2011.pdf
[2] www.gov.uk/government/case-studies/the-expert-patients-programme
[3] si.easp.es/derechosciudadania/wp-content/uploads/2009/10/4.Informe-Wanless.pdf
[4] www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf

expansion of personal health/integrated budgets. This in turn has ensured the HLP has prioritised self-care support.

National Voices (a coalition of health and social care charities) recently carried out a study on the effectiveness of self-management, shared decision-making, improving information and understanding, enhancing experiences, promoting prevention and peer support.

The self-management report collated data from 228 systematic reviews[5]. Their analysis of the most effective approaches to supporting self-management concluded (summary) that:

- There is strong evidence that self-management support helps to increase people's knowledge about their condition, how to self-care and when to appropriately use health services
- Online education and support has been found to improve knowledge in people with LTCs and mental health issues
- Most research shows that self-management support can improve people's satisfaction, coping skills, confidence perceptions and health literacy
- There is good evidence that self-management can reduce use of health services
- Self-management can reduce hospital admissions and costs
- Self-management can improve health behaviour and outcomes

The House of Care model below provides a clear picture of how self-care is central to the changes underway in the TST programme, in line with national strategy.

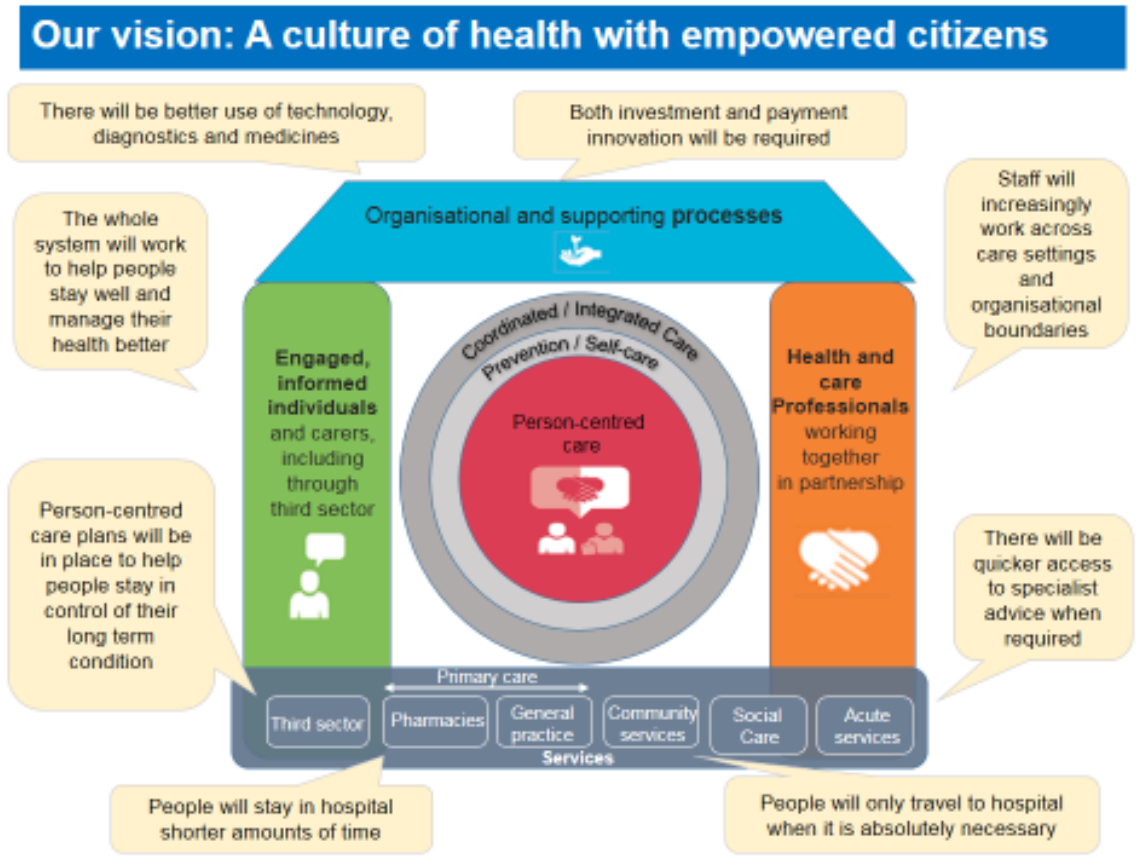


Figure 1

[5] www.nationalvoices.org.uk/pages/evidence-person-centred-care

1.2 Self-care delivery

Life expectancy is worse than the England average in Newham and Tower Hamlets. More people are dying young from a range of common causes of death such as heart disease, stroke and cancer. Hospital stays for alcohol-related harm; the incidence of diabetes, tuberculosis, and sexually transmitted diseases; and the proportion of obese children are all significantly above the national average. Whilst progress has been made towards closing the gap between the local and the national averages, local healthy life expectancy is also below the national average. On average, patients are now living for about 20 years in ill health.

There are significant benefits and savings to be made in encouraging people to look after themselves

Primary care

The primary care system needs to meet growing demand and anticipated activity shifts from urgent care and hospital based services. As a result of the TST programme, it is projected that over five years around 10% of activity will be directed to wider primary care providers (pharmacists, optometrists, counselling and psychology services) and around 8% will be accounted for by patients being better supported to self-care. This latter figure is based on national evidence[6], guidance and TST engagement to date, and will be achieved by equipping patients with the right advice, health care tools and signposting.

One of the three key principles of *Transforming Primary Care in London: A Strategic Commissioning Framework* (SCF) is proactive care. The specifications have been adopted across London[7] and WEL CCGs are seeking to deliver their benefits. The specifications work to ensure primary care teams create an environment in which patients have the tools, motivation and confidence to take responsibility for their health and wellbeing. Practices will develop an infrastructure to provide self-management support for patients with ongoing complex problems, and extend that support to carers. Under the adopted specifications, each practice will be able to fully participate in multidisciplinary work across the health and care system, and use reflective learning to improve patient care and enhance their systems.

The three WEL CCGs are ensuring that a range of support mechanisms are available to patients, including resources; advice from staff skilled in lifestyle training and/or motivational support; information packs; services provided by volunteers or voluntary organisations, and access to patient groups in which patients support each other.

Examples of commissioned self-management and support for patients already underway include:

- Newham CCG linking with the local council around active living, which covers social prescribing, motivational support, and signposting to council services that liaise with third party and voluntary organisations (via MiDoS). The Newham self-management support programme (SMSP) is a new health coaching and signposting service provided by community pharmacists, supported by primary care. This intervention facilitates and

[6] *Transforming Primary Care in London: general practice a call to action*. www.england.nhs.uk/london/wp-content/uploads/sites/8/2013/11/Call-Action-ACCESSIBLE.pdf
NHS England (2013) and Save our NHS: Time for Action on Self Care. Selfcare Forum (2013) *www.selfcareforum.org/wp-content/uploads/2013/10/Self-Care-Forum-Mandate-FINAL-single-page.pdf*
[7] www.england.nhs.uk/london/wp-content/uploads/sites/8/2015/03/lndn-prim-care-doc.pdf

supports people identified through risk stratification as being at moderate risk of hospital admission to develop a well-being plan. It provides people with the tools, skills, confidence and support to enable and encourage them to take a more proactive role in managing their own health and wellbeing.

- The Waltham Forest Wellbeing at Home (WB@H) service provides short term non-clinical support to vulnerable and socially isolated people at risk of unplanned admission to hospital. The service helps patients co-ordinate a range of services and ensures they are not just sign-posted, but effectively linked into the services which will support them to maintain wellbeing in the community and prevent unplanned hospital admissions. Support is time limited to a maximum of 12 weeks. The CCG has demonstrated that patients who entered the service reduced their healthcare usage for a period of six months after interventions were completed and has now moved this service into 'business as usual'.

  The CCG has commissioned packages of self-care from trained local pharmacists - the service is just starting.

- Tower Hamlets aims to maintain service users' independence wherever possible, by empowering them to manage their own care and support, and, at the same time, reducing pressure on the council and health care providers to provide services in a climate of diminishing resources. The approach is aligned with the Tower Hamlets Together Vanguard's objective of delivering citizen-led care and support planning, and is underpinned by the responsibilities that the Care Act 2014 places on the council to promote wellbeing through prevention.

  The Tower Hamlets Better Care Fund-supported Assistive Technology (AT) Team aims to enable greater self-management of conditions in order to prevent hospital and residential admissions. It provides training and support to social care and health professionals, and pilots and implements new initiatives and projects. The impact on carers who receive this kind of support can often make the difference between being able to continue to provide care to their loved one, or developing a need for health and care support themselves. In the last six months there were an estimated 275 requests; 295 installations of equipment and avoided costs of £132,000. AT staff have delivered 12 training sessions to 76 staff (48 Health and 28 Social Care)

Urgent care

The population is growing and in just five years, if we don't make any changes, we would expect there to be over 70,000 more attendances a year at east London's emergency departments, Whipps Cross, Newham, Royal London and Homerton. Emergency departments should be for emergencies only, yet we know from local health data that up to 21% of those who attend, but aren't admitted, require no significant treatment. Many of these people who require no significant treatment could be better cared for in other settings and /or also helped to care for themselves.

In our new model of working we will be emphasising models of self-care which will include comprehensive care plans for people with a long term condition and supporting apps which will help people manage their condition safely and reduce the likelihood of exacerbation.

We will be ensuring that people are well informed regarding the resources and services that are available to them, empowering them to choose the most appropriate pathway for their care, reducing the number of unnecessary admissions and Emergency Department attendances.

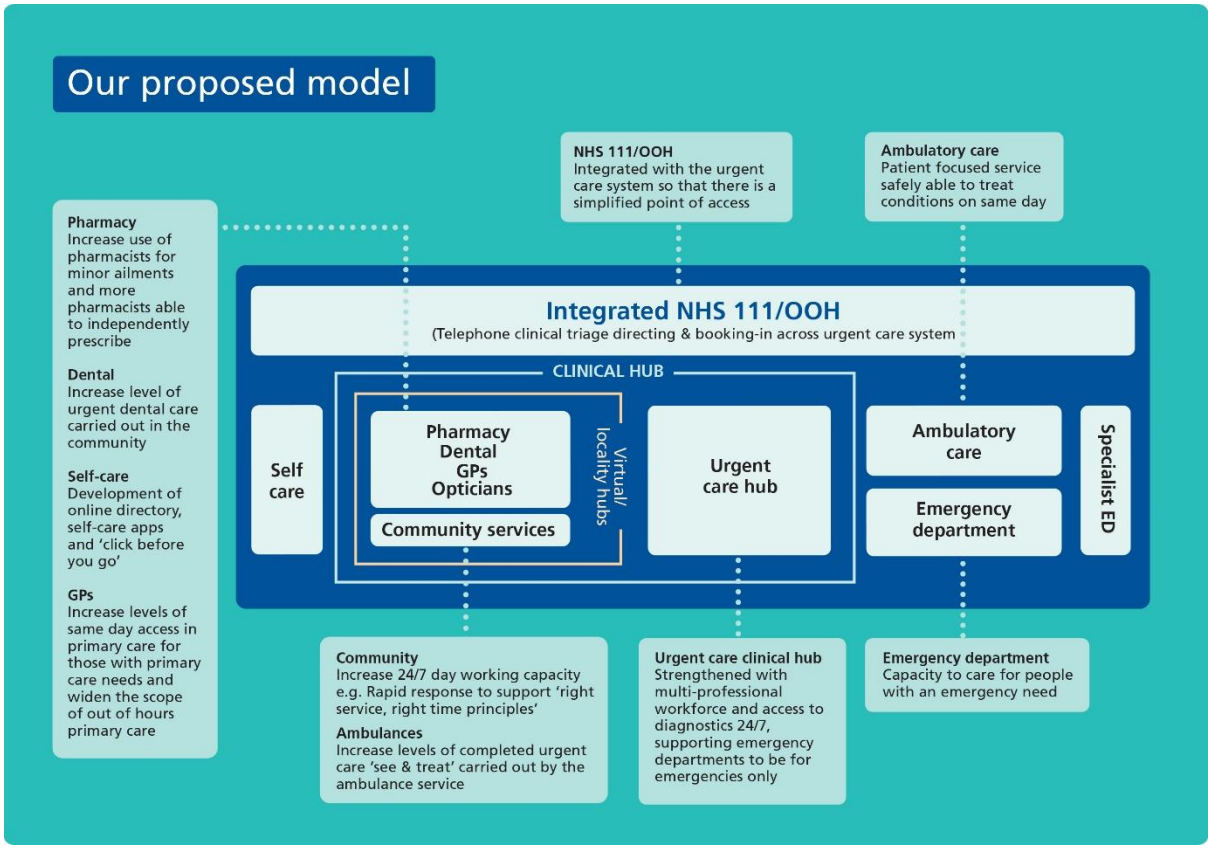


Figure 2

The NHS 111 service will be further integrated with the urgent care system to help people choose the right service, first time. The service will be able to book people into an appointment at the most appropriate service (GP, dental, urgent care centres located at our emergency departments, community services or ambulatory care[8]), so that people are seen quickly and conveniently.

Pharmacies will play an important role when people do want further support in managing their illnesses. The online directory of services will help to raise the profile of what support pharmacies can provide and the NHS 111 integrated urgent care service will also be able to direct residents to pharmacies when it is appropriate to do so.

Many people's urgent care needs if not met through confident self-care management, pharmacy advice can be met effectively by GP practices which includes a wide range of professional skill mix e.g. GP, Nurses, Health Care Practitioners. Therefore a review is being conducted on how access to appointments during the working day can be improved with more evening and weekend provision, including through telephone and online consultations.

Where the level of need indicates that further investigation is needed for the urgent care presentation we will be broadening the urgent care services at the front of emergency departments so that they can cater for a much broader range of conditions. Current services that are co-located with hospitals do not all have direct access to test facilities. This means that people are often referred to emergency departments simply to access these tests. If emergency departments are to successfully provide care within four hours, self-sufficient

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

urgent primary care centres are needed at each site that can access diagnostics directly and care for everyone without creating an unnecessary bottleneck on other resources.

1.3 Mapping existing WEL self-care interventions

In mid-2016, the TST Team began mapping self-care initiatives across the WEL boroughs and CCGs, with the aim of identifying good practice to be shared across the collaborative and, potentially, the wider STP footprint.

The team has formed links with the HLP, which has focused on 13 transformation programmes that promote prevention and self-care across London[9]. The team has been able to make connections with the National Social Prescribing Network, the London Fire Brigade, (see below), patient champions, as well as other CCGs and London boroughs. These connections help TST engage with new self-care opportunities.

All WEL CCGs and councils have now provided self-care information (see attachment).

1.4 London-wide self-care initiatives

Strategic Partnerships

The HLP is working with the London Fire Brigade (LFB) and the Co-operative Group Ltd to pool and mobilise both new and existing resources in communities across the capital to improve health and wellbeing. It is proposed that this work will expand across industry, business, voluntary and third sector partners who can make worthwhile contributions.

In July, TST supported and facilitated a request by the London Borough of Newham to engage with the LFB under its programme *Fire as a Health Asset* to help, enable and support 'at risk' individuals. In September, the LFB produced its first Community Health Strategy, outlining its intent to engage locally with public health and social care providers.

Social Prescribing

HLP is finalising a good practice resource, due to be released in November 2016 that will cover all London boroughs. WEL boroughs will be able to inform and benefit from this work. HLP and the National Social Prescribing Network have recently agreed to develop a London Network with which WEL boroughs will also be able to connect. The new network will hold its first meeting in the near future.

Integrated Personal Commissioning / Personal Health Budgets

Tower Hamlets CCG is an Integrated Personal Commissioning 'demonstrator' site and there is potential for Newham CCG and Waltham Forest CCG to engage with the national team regarding becoming IPC 'early adopters'.

There are emerging technologies – such as the use of the My Community ePurse at Harrow Council where local providers list their services on an online marketplace and clients can choose their care options online[10]. The project with 11 staff and costing £160,000 a year has saved £3 million in the last three years. This is further developing into a service where issues can be typed in, and local service options are presented.

[9] www.myhealth.london.nhs.uk/system/files/Case%20for%20Change%20Summary%2011.pdf
[10] harrowmonitoringgroupupdated.wordpress.com/2015/11/01/my-community-e-purse-take-up-is-set-to-improve/

1.5 Measuring success

The TST team is creating a set of metrics to assess how well the programme is achieving its goals of increasing sustainability of health services and improving health outcomes. These metrics bring together progress made on implementing TST initiatives with changes in activity or costs across the health care economy, along with improvements in care quality. This will also include measurements for how well patients are managing chronic conditions, among others, to reflect the importance of self-care.

Patient Activation Measures (PAM) [11]

Measuring patient activation is a core enabler for the NHSE self-care programme. The PAM is a series of (usually 10-13) questions designed to assess a patient's knowledge, skills and confidence to manage their own health and healthcare. Depending on their responses, patients are allocated 1 of 4 levels of activation. The level may change up or down each time a response is provided. Health and care systems that know the activation level of their population can begin to tailor their services in order to support people on a 'journey of activation', thus helping them lead better lives at a lower cost to the system. PAMs can only be used by healthcare organisations if they have successfully applied for licences.

In June 2016, licences were approved by NHSE for all three WEL CCGs. Since then:

- Waltham Forest CCG has engaged NELFT to collect PAM scores from new patients, and is negotiating with local pharmacies to offer PAM to patients.
- Tower Hamlets CCG has incorporated PAM into its integrated care Network Improved Services (NIS) arrangements with GP practices for 2016-17.
- Newham CCG now requires all GPs and pharmacists who sign up to the Self-Management Support Programme (SMSP) to make PAM assessments available to patients (GPs refer to pharmacies which conduct the assessments). The CCG is also negotiating MoUs with ELFT, West Ham United Foundation and the London Borough of Newham to deliver PAM.

1.6 Summary

Whilst the TST programme has always highlighted self-care as a cross-cutting theme of the Care Close to Home (CCH) workstreams, the TST team has renewed its approach to this area by engaging with WEL boroughs and CCGs specifically on self-care and forging links with supportive bodies like HLP.

Using the self-care mapping work, the TST team will work collaboratively with organisations to encourage and support a broader uptake of successful interventions across the boroughs.

The collection of information on self-care financial modelling and metrics will help to demonstrate the quality and financial benefits to be achieved from self-care interventions.

The team will also work with TST communications and patient groups to ensure that high quality interventions are successfully communicated throughout local communities.

[11] www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/

2. Elective (planned) surgery

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

- Part 2, Chapter 3.3. Strong sustainable hospitals
- Part 2, Chapter 4.5. Establish surgical hubs
- Part 3, Chapter 5 Establish surgical hubs, including interventional radiology.

2.1 Background

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

Although there are examples of parts of the system working well, patients are receiving variable standards of care and the current configuration of services is not the most effective use of surgical resources[12]. For example:

- The quality of care can be improved. Currently, because each of the three main sites delivers similar elective services, surgeons and their teams in some hospitals see low numbers of patients despite evidence showing that higher numbers of patients are associated with better outcomes[13]. The Care Quality Commission (CQC) has also inspected the three sites and found quality issues that need to be addressed
- A large number of non-complex operations take place at the Royal London Hospital, causing high bed occupancy; there is also unpredictability and a large volume of unplanned operations. This means emergency surgery and planned surgery are not effectively separated. Separating emergency and planned services has long been recommended[14] to improve a range of patient outcomes including cancelled operations, reductions in infections, patient safety etc. Cancellation of planned operations causes distress to patients, results in many wasted journeys to and from hospital and makes it difficult for patients and their families to plan their work and family life. The high bed occupancy and difficulty in separating emergency and elective surgical services (including a lack of ring-fenced beds) contributes to, in some specialities, up to 20% of elective operations being cancelled[15].
- The system is not efficient. Expensive to maintain specialist equipment is often available on all three sites – even if there are very few procedures carried out there. Staff shortages/illness have a huge impact. The shortage of one specialist at one site and a different specialist at another site means two teams out of action. A combined team would be more flexible.

[12] *Case for Change*. East London CCGs Transforming Services Changing Lives programme. 2014
[13] 2007 *A systematic review of the impact of volume of surgery and specialization on patient outcome*. M.M. Chowdhury, H. Dagash and A. Pierro www.onlinelibrary.wiley.com/doi/10.1002/bjs.5714/pdf
[14] www.rcseng.ac.uk/library-and-publications/college-publications/docs/seperating-emergency-and-elective/
[15] Surgenet data. Barts Health internal performance metrics Jan-Jul 2015

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

2.2 Surgical Hub Benefits

As demonstrated in the Transforming Services *Changing Lives Case for Change*, changing the configuration of surgical services across east London would maximise patient safety and contribute to making the services more sustainable. A new configuration of services would ensure more low risk surgical procedures are taking place at residents' local hospitals and continue to deliver pre-operative and post-operative care closer to people's homes whilst:

- improving outcomes, providing safer services and making quality provision more sustainable
- strengthening cross-site working and improving inter-hospital transfer arrangements
- developing a safer emergency surgery model, strengthening network and triage arrangements across all sites. The use of surgical hubs helps secure specialist expertise, workforce and training regimes which support the long-term future of A&Es at each hospital site.
- addressing challenges such as staff shortages, low demand at each site for specific surgical procedures and the high costs of maintaining specialist equipment. Additionally, Barts outsources some of its work to independent providers to ensure patients are seen as soon as possible. By utilising spare capacity and improving efficiency and productivity it can reduce reliance on external providers and obtain better value for money for taxpayers.

Patients will find that most care is delivered locally, with further travel needed only when it leads to better outcomes. For example Whipps Cross could specialise in operations for older people, which helps means that local residents (who tend to be older than residents in Newham and Tower Hamlets) would not need to travel as far to get the care they need.

Lengths of stay have decreased phenomenally in the last few years due to improvements in anaesthetics, keyhole surgery etc. Most patient stays are less than three days; hip replacements are commonly day surgery. Establishing surgical hubs will further reduce lengths of stay, so any perceived disadvantage for relations and carers having to travel further are likely to be negated by the very small number of days (commonly only one) that patients will be in hospital.

2.3 Proposal

We want to establish surgical hubs at each Barts Health hospital site that work together in a network to deliver safer, more sustainable and higher quality care. Surgical hubs can improve outcomes for patients, making best use of the estate and gaining efficiencies from the economies of scale. Sites within the surgical hub model are classified into three categories:

'Core' surgical services support emergency, medical and maternity care and should be available on all sites and include less complex, elective surgical procedures that can be run

in dedicated short stay, day case or outpatient facilities. Examples include low risk emergency general surgery, non-complex gynaecology surgery, some vascular services, urology pre-operative care, post-operative care and endoscopies for urology and gynaecology.

'Core plus' surgical services require a degree of specialisation and/or additional resources. They require a concentration of the specialist workforce and dedicated capacity for care to be delivered safely and sustainably. All three hospitals would have a core plus service, but it would be different at each hospital. Examples of core plus services include arthroplasties (currently provided at Newham Hospital), coloproctology and general breast surgery.

'Complex' surgical services are required to support the treatment of cases such as complex cancer or trauma. Clinical interdependencies and the input of multiple specialities are crucial to optimise safety and patient outcomes. Examples of complex procedures include complex emergency surgery, specialist cancers e.g. gynae-oncology surgery and high risk elective surgeries.

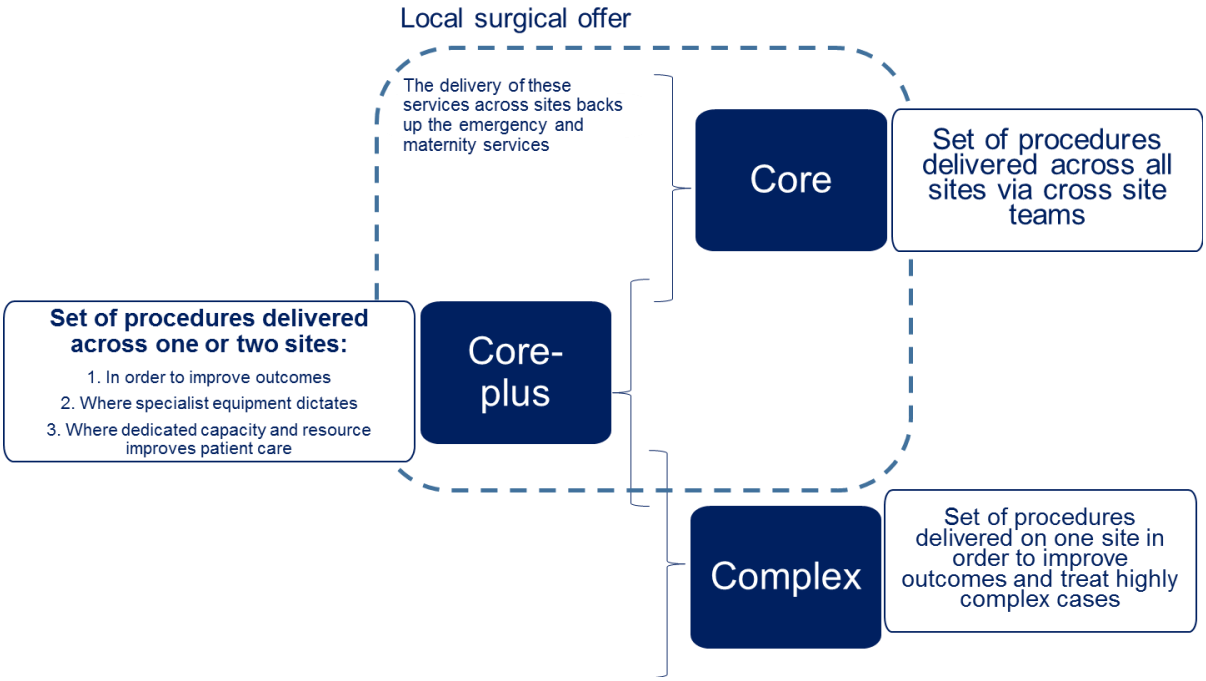


Figure 3

We are very mindful that we require the involvement of service users, carers and for example, the voluntary sector. We are always dealing with new relationships for which we need to use a new language of inclusion and it is our intention to ensure that we reach out to those whose voices are seldom heard. By working together, as equal partners, we can deliver better care to those who most need it. As we develop these services we want to work closely with our service users to ensure that the development of surgical hubs will deliver the care they need in the most suitable setting. To this end we shall be setting up user groups to support this work.

2.4 Surgery changes

There are three surgery changes due which aim to utilise spare capacity and address some of the issued described above. Colorectal and urology changes will not restrict choice, but offer patients a faster service in a local hospital , with pre- and post-operative services at their nearest hospital.

- **Colorectal surgery**

Expand capacity at Newham from November 2016 through increased theatre efficiency and more staff so that 70-100 more operations per year can be done there instead of at RLH or Whipps Cross (roughly equal numbers from both). Patients will still be able to choose to have their operations at any of the three hospitals. Currently there are around 1,000-2,000 cases a year at each hospital.

- **Urology surgery**

Use increased medical staff and underutilised theatre capacity at Whipps Cross from April 2017 so that c100 operations can be done there instead of at RLH. Patients will still be able to choose to have their operations at any of the three hospitals. Currently around half (1,600-2,000) of the total urology operations a year are done at RLH.

- **ENT (paediatric adenoid surgery and tonsillectomies)**

Use unused theatre capacity at Whipps Cross from November 2016 so that the c.100 operations we do each year could be done there instead of at RLH. RLH would retain ability to perform this surgery but would not routinely offer it.

Additional plans are under development for other surgical procedures to make the best of available resources and deliver better services for patients. We will work with service user groups to identify and scope the next phase of development so that this is a truly inclusive process.

3. Movement of services and patient journeys (acute patient pathways)

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

- Part 2 (Main report) page 5: Our population and our services
- Part 3 (High impact changes) pages 82-101: Establish acute care hubs at each site – the case for change

3.1 Introduction

This paper seeks to highlight the purpose of acute care activities, aligned to a shift in how and where services are delivered, as outlined in the *TST Strategic Investment Case.*

We are looking to strengthen the provision of integrated services in a community setting, enabling people to better manage their health and where appropriate supporting them in receiving the right care at the right time, in the right setting. These interventions reduce the number (and length) of journeys for patients and their family/carers

We are also seeking to implement clinically driven models across Barts Health sites focusing on how acute care hubs (including ambulatory care services) will support patients in receiving safe, sustainable and high quality services. Ambulatory care models enable hospitals and community services to treat people who do not need 24-hour nursing care, outside of a hospital bed. This also includes access to specialist input on the same day, to avoid unnecessary admission to a hospital bed, whilst ensuring best practice treatment and patient experience.

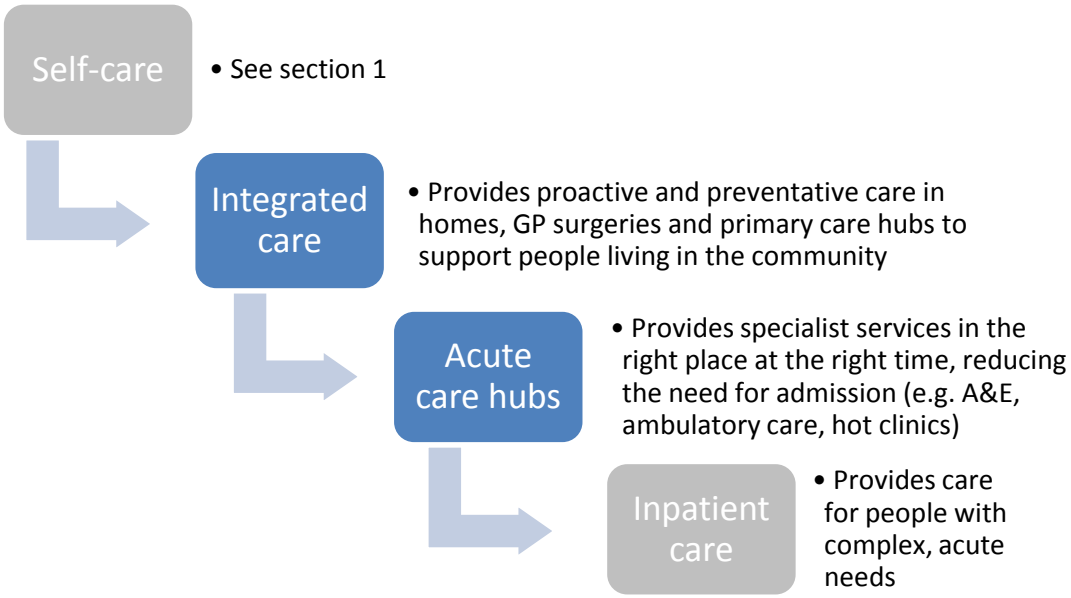


Figure 4

The following sections describe the integrated care and acute care hub/ambulatory care approaches in more detail. However it should be noted that these are only part of the solution to manage resources and provide better, quicker urgent care. For instance, it is estimated that nationally over 50% of 999 ambulance calls could be treated at the scene. In

Newham, paramedics carry hand-held devices that enable them to access patients' primary care records to better treat people quickly.

3.2 Integrated care

As part of a wider plan to support patients to better manage their health, integrated care plans are being developed and implemented.

We have integrated care plans for over 30,000 people and are developing an additional 35,000 plans this year. This planning will ensure that those people at medium risk of hospital admission receive coordinated, effective care close to their home wherever possible (people at high risk if admission have already been identified and services targeted at them) helping them manage their health better, stay well, be able to live in their own home or the community (rather than have long spells in hospital) and reduce their reliance on urgent care services.

The projected savings from the introduction of integrated care over the next five years are between £4.2m and £6.6m.

In line with the Integrated Care Case for Change, and as reflected in the commissioning intentions for 2016/17, commissioners and local authorities in each borough are developing local integrated care plans and identifying opportunities for joint commissioning. Joint statements will set out a commitment to work together to:

- develop local integrated care services
- jointly commission where appropriate
- redesign services such as therapies and learning disabilities
- introduce and take full advantage of the use of personal health budgets
- maximise early intervention

For example:

- Every GP practice in WEL has a monthly health and social care MDT meeting to discuss complex patients[16].
- New, more efficient and effective care pathways are being designed so that patients experience more individual care. More services are to be provided in the community, but some services and specialties also need to be brought together in the same place where there are clear advantages to patients in doing so. In the last three years there has been a 25% reduction in the number of emergency admissions to Whipps Cross hospital due to better integrated care.
- Primary care hubs will offer a wide range of co-located services, offering improved access and reducing the need for multiple visits to different locations in order to access health services – making efficiencies and improving patient experience.
- The integrated care programme has already seen the development and introduction of some new roles such as care navigators, who coordinate the planning and delivery of care to patients most at risk of hospital admission by working with staff from different providers including those in primary, community and social care.

[16] A video is available about the Newham MDTs and how it helped a father and son. http://welccc.nhs.sitekit.net/

In addition, a proportion of primary care activity seen in general practice can be supported through other roles such as pharmacy care enabling general practice to have more capacity to support the delivery of more complex care.

Integrated care coordinates care and helps empower people to better manage their own conditions, whilst being supported by specialist advice, and helps to reduce pressure on the system as people are seen in the most appropriate setting.

3.3 Acute care hubs

The development of acute care hubs is supported for a range of reasons including:

- a requirement to put patients' needs first by redesigning hospital services, as recommended through the *Future Hospital Commission*[17] by the Royal College of Physicians and in keeping with the Royal College guidelines[18]
- recognition that too many patients are admitted to hospital because there are not the dedicated facilities to treat them appropriately and send them home safely the same day. By developing a range of ambulatory services, Barts aims to reduce non-elective admissions by 15% overall.

Acute care hubs bring together the clinical areas of medical divisions that focus on the initial assessment and stabilisation of acutely ill medical patients. Only patients needing care likely to take longer than 48 hours are then admitted to a specialist ward.

This means establishing new ways of rapidly accessing specialist medical and surgical assessment through effective use of multi-speciality short-stay wards and same-day access to clinics, including:

- an increase in onsite emergency consultant cover from a current level of 12 hours per day towards a minimum of 14 hours a day, seven days a week and working towards 16 hours a day within the next three years
- rapid assessment and triage by a senior decision-maker in the emergency departments.
- onsite paediatric consultant cover between 10am and 10pm, seven days a week.
- adherence to the new pan-London mental health crisis standard which requires people to have timely access to on site liaison psychiatric services
- 24/7 ability to assess, safely stabilise and transfer patients through agreed specialist pathways.
- 24/7 timely access to high quality diagnostics (imaging and laboratory, endoscopy, echocardiography and physiological testing).

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

[17] Royal College of Physicians: *Future Hospitals Commission*. 2014 www.rcplondon.ac.uk/projects/future-hospital-commission

[18] www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-10-ambulatory-emergency-care

Newham and Whipps Cross could have: *The Royal London could have*

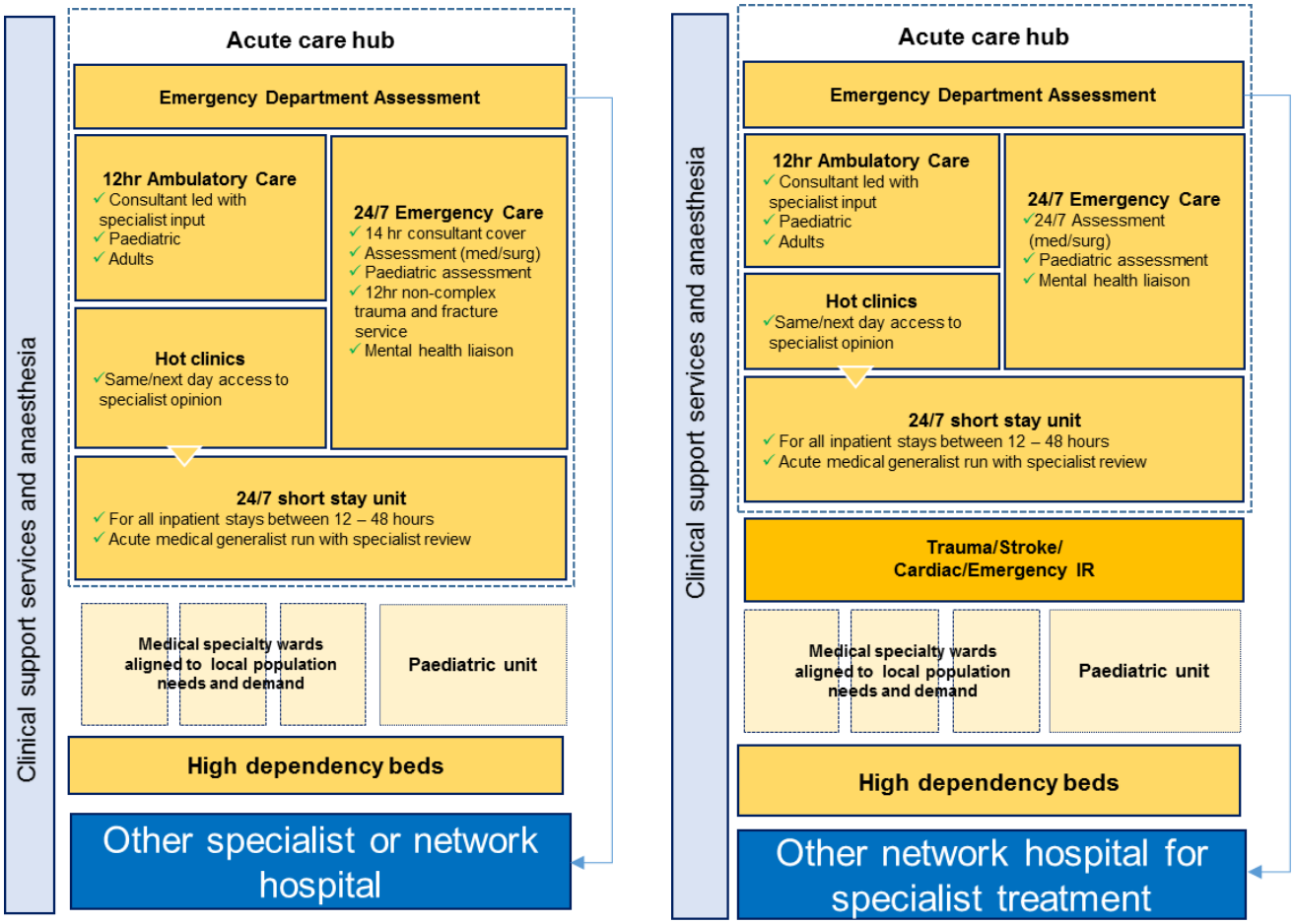


Figure 5

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

- In Newham, introduction of ambulatory care avoided 90% of admissions with projected stays of under one day[19]
- Ambulatory care can be used to support an earlier discharge for patients otherwise ready to go home
- Delivering care through an ambulatory care model can improve emergency department performance[20]
- When asked about the care they received through ambulatory care models, patients have provided extremely positive responses.

[19] Presentation: Stepping into the Future, Phase 2 at Newham, June 2015
[20] *Running a Bigger, Better Ambulatory Care Unit,* Whipps Cross Hospital pilot, May 2015

Case study:

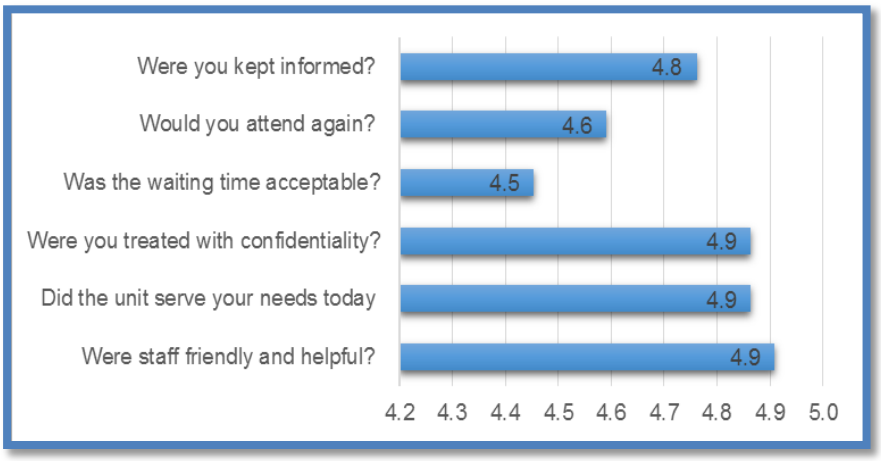
An ambulatory care pilot service at Whipps Cross in 2015/16 recorded 4,410 ambulatory visits.

Around 40% (1,774) of these were follow-up appointments. Of the remaining 2,636 patients, data collected suggests that just over 700 would have otherwise been admitted – thus the hospital is averaging 24 avoided admissions per week.

The Royal London Hospital model focuses on patients who would otherwise need admission. In 16/17 to date, RLH is avoiding admitting 28 patients a week through this model (4.9% of the total number) with increasing numbers in recent months.

Newham University Hospital manages around 6,000 ambulatory patients a year via its Clinical Decisions Unit, run by the emergency department. The CDU and other areas have beds which provide an alternative to discharge or hospital inpatient admission for the emergency department patient who may benefit from an extended observation period.

Patient experience average response scores from Whipps Cross ambulatory care pilot 2015 (1-5 range)



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Self-care Initiatives across Waltham Forest and East London

Contents

1. Patient Education & Health Literacy (inc information/advice services)

Newham

- Healthwatch: http://www.healthwatchnewham.co.uk/ (Independent of Local Authority and NHS)
- Access Team - Independent Advocacy Group (IAG)
- Community Neighbourhood Link Workers (generic health and social care)
- Public Health campaigns via Community Pharmacies (3 national, 3 local)
- Sexual Health promotion - Young people sexual health service. HIV Prevention and Support services.
- Diabetes Specialist Team (diabetes education courses)

Tower Hamlets

Patient Education

- XPERT Patient Programme - Structured Education Programme for Type 2 Diabetes (Commissioned from Community Health Services)
- DIANA - TYPE 1 Diabetes Education Programme (Commissioned through CHS)
- COPD Programme/Pulmonary Rehab - (Commissioned through ARCARE service in CHS)
- Cardiac Rehabilitation & Heart Failure team (Commissioned through CHS)
- Voluntary sector, Social Action for Health, including a number of self care services inc: Key Short message for Diabetes, Chronic Kidney Disease, Cardio Vascular Disease & Hypertension

The majority of Tower Hamlets Council commissioned services (including joint commissioned services with the CCG), stipulate a commitment from voluntary sector providers to provide health related activities and health promotion (e.g. Lunch clubs may offer exercise and have visiting topic-based sessions led by health professionals, while LinkAge Plus provides a broad range of activities and knowledge sessions). http://linkageplus.co.uk/our-services/activities/

The LinkAge Plus contract contains a target of 1,200 Physical Activities sessions and 656 Healthy Lives sessions per annum. In 2014/15, the network exceeded both of these targets, delivering 1,255 Physical Activities sessions and 656 Healthy Lives sessions.

A jointly commissioned LA and CCG service, which provides an online directory of service for mental health and wellbeing as part of the recovery and wellbeing commission services, can be accessed by residents. https://www.ideastoreonlinedirectory.org/kb5/towerhamlets/cd/mentalhealth.page?communitychannel=10

Through the integrated care approach, a Mental Health Recovery College has been jointly commissioned, which will provide an education-based approach to mental health recovery and management of long term conditions. It will run a curriculum over three terms per year, offering a minimum of 20 courses each term for 600 students per year. The Recovery College will use a range of community venues across the borough for delivery of courses to ensure equitable access in localities. This is intended to reduce barriers due to local neighbourhood, transport and mobility issues.

As part of the development of the Carers Strategy, there is an early indication that carers feel they would like 'specialist' support in maintaining their caring role. The model Tower Hamlets Local Authority would like to explore focuses on a collaborative partnership between agencies, patients, individuals including carers and their communities in order to establish a 'virtual' academy which promotes self-care and patient and carer wellbeing. This work would encompass both bespoke patient educational programmes and carer-specific support to aid management of conditions, such as cardiovascular disease, stroke, COPD, diabetes and dementia.

Public Health commissioned the development of ESOL modules, which focused on a range of specific health topics (including diabetes, mental health and cancer) and provided information on the key health messages, with the aim of improving the health literacy of participants of the ESOL classes.

Waltham Forest

Health Coaching for Respiratory patients, telephone service

- EPP Health Coaching

2. Collaborative consultations & shared decision making

Newham
Independent Advocacy

Tower Hamlets
Across LBTH Adult Social Care (ASC), services are carrying out personalised assessments and support planning for residents and their carer to support their independence and wellbeing in alignment with the Care Act 2014. Teams including the Personalisation & Review, Assessment and Intervention, Community Health (CHTSC) and others in ASC in partnership with health and voluntary sector providers engage and ensure they maximise independence, choice and control for service users. Direct Payments and Personal Budgets are promoted:
http://www.towerhamlets.gov.uk/lgnl/health__social_care/what_to_expect_from_adult_soci.aspx

The council is also exploring a range of co-production models, which enables residents/service users to shape and provide their insight and experience into shaping future strategies and commissioned services.

A number of partnership board arrangements (e.g. Carers, Older People, Mental Health and Learning Disabilities) are being reconfigured to ensure service users and carers are able to contribute fully to decision making, alongside relevant professional bodies.

Tower Hamlets Together (formerly THIPP) is developing a stakeholder council comprised of members from a range of different groups and organisations. Each member represents people with different types of needs. Although still in the early stages of development, the stakeholder council will provide invaluable input and challenge to the Tower Hamlets Together Board that will contribute to decisions about the way care is provided in the borough. The Vanguard-funded Community Research Network (CRN) is another new THT initiative led by Public Health. It will bring together local residents to gather local intelligence that will inform the various partnership workstreams. It will also support the functioning of the Stakeholder Council and will be able to inform wider pieces of commissioning in the future.

Waltham Forest
Part of the general Integrated Care system. Goals are set with patients by community health staff within the context of the high risk patient cohort

3. Personalised care planning and delivery

Newham
Form part of support plan for eligible customers and carers, enablement, equipment and adaptations, telehealth, telecare, IAPT programme, diabetes care plans, CVD care plans.

Tower Hamlets
Integrated Care Network Incentive Scheme (commissioned from GPs) incentivises general practice to do care planning. Also included in the Diabetes NIS.

Also have Care Planning for Continuing Care for Children as part of Personal Health Budgets
- As part of WEL/TST work are working on a single care plan

All Adult Social Care teams provide personalised care planning and delivery. This includes Personalisation and Review, Assessment and Intervention, Reablement, Telecare, Assistive Technology, Community Equipment, 7 Day Hospital Social Work Team and Community Health Team. Service users are encouraged to complete a self-assessment to identify their needs - including support from friends, family and their local community, as well as statutory council funding for needs - which can have a significant impact on a service user's wellbeing. To ensure better and coordinated planned care, social care services attend multi-disciplinary team meetings. Some teams, such as the 7-Day Hospital SW Team and Community Health Team are co-located with health. In addition, a number of services have been enhanced to provide extended hours in the evenings and at weekends.

Waltham Forest
Part of the general Integrated Care system. Goals are set with patients by community health staff within the context of the high risk patient cohort

4. Peer Support

Newham
Independent Advocacy, Support group for employers of PA's IAPT programme, Diabetes Support Club

Tower Hamlets
All services listed in patient education above include elements of Peer Support
There are also a number of services commissioned by the LA for particular groups e.g. SEND

A number of service user groups provide peer support (for example, the Older People Reference Group, PAN Provider Forum, REAL, and Have Your Say (Learning Disabilities)). Commissioned services are also encouraged to organise their own service user groups (e.g. the Carers Centre runs the Carers Forum).

Waltham Forest
Metropolitan Housing project "Wellbeing at Home" to support residents with social and housing issues on discharge from hospital or to prevent admission to hospital

Age UK befriending service

5. Personalised Health Budgets (PHB) / Integrated Personal Commissioning (IPC)

Newham
http://www.newhamccg.nhs.uk/services/personal-health-budgets-eligibility.htm
Since October 2014, adults eligible for NHS Continuing Healthcare and children eligible for continuing care have had a right to have a personal health budget. As well as continuing to offer personal health budgets to these groups, as of April 2016, Newham CCG will now offer personal health budgets to a limited number of long term conditions housebound patients with Chronic Obstructive Pulmonary Disease (COPD) and patients who have been identified as needing a wheelchair, following referral and assessment from the wheelchair service. We will also be exploring providing personal health budgets in mental health, physiotherapy, occupational therapy and speech and language services.

Tower Hamlets
LA provides personal budgets for people with social care needs. Health offer Personal Health Budgets for adults and children with continuing health care needs. Are also expanding the offer to LD, SEND, people with LTCs and Mental Health needs as part of the Integrated Personalised Commissioning (IPC) programme those with health/social/educational needs may be offered a joint budget.

Waltham Forest
Personal Budget project has commenced and resource allocated within WF CCG to ensure this proceeds.

6. Asset Based Community Development

Newham
The CCG is working to develop a community development approach through the Staywell,partnership using community prescription vehicle (see below.)

Tower Hamlets
CCG - As part of IPC we are looking at the role of the wider community in supporting people to meet their outcomes.

The Council commissions and delivers a number of preventative/population health services that educate service users and address issues such as social isolation. The council also seeks to enable service users to reduce dependency on social care services. Public health is delivering work around locality- based services, which includes providing a community budget. Tower Hamlets Voluntary and Community Sector strategy will also strengthen and enhance this work.
http://www.towerhamlets.gov.uk/News_events/News/June_2016/New_voluntary_sector_strategy_launched.aspx

Waltham Forest
Local Area Co-ordination. Locality based service to assist residents to connect to local community services.

7. Partnerships with community partners

Newham
Home & settle service, Community Neighbourhood Link workers, Stroke services, Dementia services, Newham Community Prescription (West Ham Foundation, Active Newham, Staywell partnership)

Tower Hamlets
The council commissions a number of services for LD, SEND, Mental Health etc., some of which are jointly commissioned with the CCG. It works in close partnership with ELFT, Barts, local voluntary sector providers, such as Link Age+ and the Alzheimer's Society, and the local authority has a Community Voluntary Sector strategy which will be embedded in new contracts. www.towerhamlets.gov.uk/providers
www.towerhamlets.gov.uk/communitycatalogue
http://towernet/document_library/procurement/market_information/Procurement_Policy_Imperatives

The council has established a Pan-Provider Forum www.towerhamlets.gov.uk/providers as well as a community catalogue www.towerhamlets.gov.uk/communitycatalogue. The Pan-Provider forum meets quarterly and is made up of all adult social care-commissioned services. To ensure transparency, updates are posted for providers on the internet regularly. The Catalogue is fully implemented and successful, and the council has included most services that it commissions. The Catalogue also includes non-commissioned services, which go through a quality assurance process before being listed. Service users are able to log in to the service, search for services, shortlist them, buy services and leave reviews. The e-marketplace element is also functioning as service users are able to purchase services. Highly recommended as a successful good practice model by Skills for Care.

The Community Catalogue has two elements: it is a directory of care and support services for adults requiring social care support, and also an e-marketplace that allows service users to purchase services.

The Pan-Provider Forum meetings are a forum for consultations and offer an opportunity for providers to raise queries with senior council officers. Important developments, such as new strategies relating to adult social care and providers, will have implications for our providers. The forum offers the ideal avenue through which providers can be informed about such matters. Providers value being consulted and appreciate workshop-style sessions via the Forum meetings that allow opportunities for discussion and consideration of key issues.
www.towerhamlets.gov.uk/providers
www.towerhamlets.gov.uk/communitycatalogue

Waltham Forest
See Living Well Waltham Forest Service (LWWF)

8. Social Prescribing

Newham
Newham Community Prescription - Physical Activity on referral (CVD / Pre-diabetes)

Tower Hamlets
Commissioned the GP Care Group to run an 18 month pilot and recommend a model to be rolled out across all GP practices in Tower Hamlets

Waltham Forest
Social prescribing service has commenced.

9. Community volunteering for health

Newham
Good Gym, ActiveNewham

Tower Hamlets
All providers contracted by the Council are expected to demonstrate economic benefits, which include apprenticeships, volunteering opportunities, etc. in proportion to the value of the contract. The council also has a corporate volunteering strategy to which all council services are committed.
http://www.towerhamlets.gov.uk/lgnl/business/tenders_and_contract/tender_opportunities.aspx
http://towernet/staff_services/procurement/procurement_policy_procedures/?view=Standard

In 2014/15 LinkAge Plus achieved 4,002 regular volunteering opportunities and 2,531 'one-off' volunteering opportunities.

Waltham Forest
Planning for a 'Living Well Waltham Forest Service': a trained volunteer service to assist residents. This will cover a number of the strands

10. Volunteers as part of NHS family

Newham
The CCG is working to develop volunteer activity through our support to Patient Participation Groups.

Tower Hamlets
The council is establishing a volunteer network, Tower Hamlets Social Movement for Life, which will support patients, patient groups and citizens (individually and collectively) to become active in developing their own health and wellbeing, and support the health of others. This service will support both social prescribing and the Wellbeing Hub in the delivery of their outcomes. Volunteering is seen as both an enabler and a result of social prescribing and signposting. The integration of volunteering into health and, eventually, social care is

about finding people - inside and outside the GP surgery/services and the wellbeing hub initially - who want to volunteer, and who could benefit from volunteering, and matching them with people, activities and initiatives that need support. It is in essence a brokerage service.

Health Champions are volunteers recruited to help the Health Trainer service. There is a target of 10 per provider organisation (40 in total).

Waltham Forest
See Living Well Waltham Forest Service (LWWF)

11. Co-production with local communities

Newham
Co-production on various projects

Tower Hamlets
Likely to exist in different ways across different projects. One example is the use of a peer support/co-production group for IPC
Another example is the work that has been done on the patient leaders programme. Where members of the public have gone through a training programme to support their involvement in future projects e.g. procurement.

The council collates and publishes an annual service user report, which is published on the internet. http://www.towerhamlets.gov.uk/Documents/Adult-care-services/Quality-of-services/77.10-A4-Local-Account-Magazine-May-2015-FINALv3.pdf

The council is developing a process to ensure that service users and carers are involved in procurement in a meaningful way (e.g. carers are being consulted on the 2016-2019 Carers' Strategy). The Learning Disability Board is also progressing to involve and embed service user views within its service remit.
The Council is committed to promoting co-production and sustainability, which is at the heart of the new Community and Voluntary Sector Strategy.

Waltham Forest
See Living Well Waltham Forest Service (LWWF)

12. Patient Activation

Newham
Get Active, Get Healthy (exercise programme), enablement, sensory training, mobility training. Newham Community Prescription, Self-management (pharmacy CCG service)

GPs and pharmacists who sign up to the Self-Management Support Programme (SMSP) with Newham CCG are required to make PAM assessments available to patients (GPs refer to pharmacies which conduct the assessments). Newham has a contract with *Sonar* to

facilitate this (to ensure the data can be correctly collected and made available in EMIS). PAM assessments are currently available under this programme.

Newham is in the process of negotiating a MoU for the transfer of licences to ELFT for use within their Extended Primary Care Team services specifically the care navigator and telehealth services. ELFT are also exploring whether licences can be used by their rehab support workers

Newham is in the process of negotiating a MoU with *West Ham United Foundation* to deliver PAM under the Community Prescription Programme. This programme is about providing local people at risk of both diseases with the chance to get involved in a broad range of tailored physical activities with GPs referring patients over 18. An article on the programme (aka the 150 club) can be found here:
http://www.newhamrecorder.co.uk/news/hammering_home_a_healthy_message_1_4542562

Newham CCG is also in the process of negotiating a MoU with the Council to use PAM licences.

Tower Hamlets
TH is one of the NHSE Pilot sites for Patient Activation Measures (PAM) as part of this project PAM is being used across a number of self management projects as an outcome measure for the service, and also as a tailoring tool to adapt the way care is provided to a person's level of knowledge skills and confidence in managing their condition.

Adult Social Care services staff attend Making Every Contact Count Training delivered by Public Health, so that they are able to have positive conversations with support service users, who would benefit from advice and signposting for support on issues which effect long term health, including smoking, poor diet, and lack of physical activity. The 1/2 day training provides information on key health messages and an introduction to a brief intervention tool to facilitate the conversations.

Fit for Life has been commissioned by Public Health to support people with long-term health conditions to improve their health outcomes, by engaging with weight management and physical activity programmes. Each individual participant will be supported over a year to help motivate them to achieve the health improvement goals they have set themselves.

THCCG has incorporated PAM into its integrated care Network Improved Services (NIS) arrangements with GP practices for 2016-17.

Waltham Forest
WFCCG has engaged NELFT to collect PAM scores from new patients, and is negotiating with local pharmacies to offer PAM to patients.

13. Digital Engagement

Newham
DOS and Adult Social Care IAG and Website, Telecare, Telehealth
https://dos.newham.gov.uk/

Telecare: eg - a personal alarm often worn round the neck to call for help when you need to. https://adultsocialcare.newham.gov.uk/pages/telecare.aspx

Tower Hamlets
The Council has included a Community Catalogue for Service Users and the general public on the internet. This provides a comprehensive list of internal and external services available to TH residents. http://communitycatalogue.towerhamlets.gov.uk/

The Assistive Technology Team, including the Telecare Team, undertakes a number of pilot projects each year which support service users and train health and social care staff to ensure they are well informed as technology is updated. Assistive Technology is jointly funded by Health and Social Care.

The AT project is an ambitious attempt to integrate the use of existing and leading-edge technology into mainstream social care and health provision. The challenge has been to overcome the natural resistance to change, and to convince staff and service users that AT is effective in supporting or replacing traditional care packages.

The Community Equipment Service has started to use an improved hoist/robotic technology which lessens the demand of double care (i.e. care needing two people), thus demonstrating innovative technology and being efficient. Training sessions will be run for practitioners involved in organising, moving and handling support for people. This will cover new procedures, equipment and positive risk taking when setting up support. The new approach will be for single-handed care to be the default, with double-handed care being the last resort. OT and Social Work practitioners in hospital teams, adult front door teams and Reablement will be the first cohort to receive training. However, training should be rolled out to practitioners in other teams by September 2016.

The council is committed to developing a digital strategy and aspires to engage service users and providers on digital engagement.

Waltham Forest
Integrated Directory of Services. Project underway but directory has not yet been completed

Transforming Services Together

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

17 November 2016

Context

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

7 November

- Introduction
- Financial implications
- Workforce implications

17 November

- **Self care**
- **Elective care**
- **Movement of services and patient journeys (acute patient pathways)**

Self-care

Case for change

Supporting people to take an active role in managing their own health and staying well is critical. There are significant opportunities. For example:

- More people are dying young from a range of common causes of death such as heart disease, stroke and cancer
- Hospital stays for alcohol-related harm; the incidence of diabetes, tuberculosis, and sexually transmitted diseases; and the proportion of obese children are all significantly above the national average
- On average, people are living in ill-health for about 20 years
- 5-8% of hospital admissions are the result of avoidable, medicine-related illnesses.
- 21% of people who attend hospital but aren't admitted require no significant treatment
- 5-10% of people do not attend their GP appointments and 19% don't attend hospital outpatient appointments
- Social, economic and environmental factors tend to lead to poor health in our boroughs

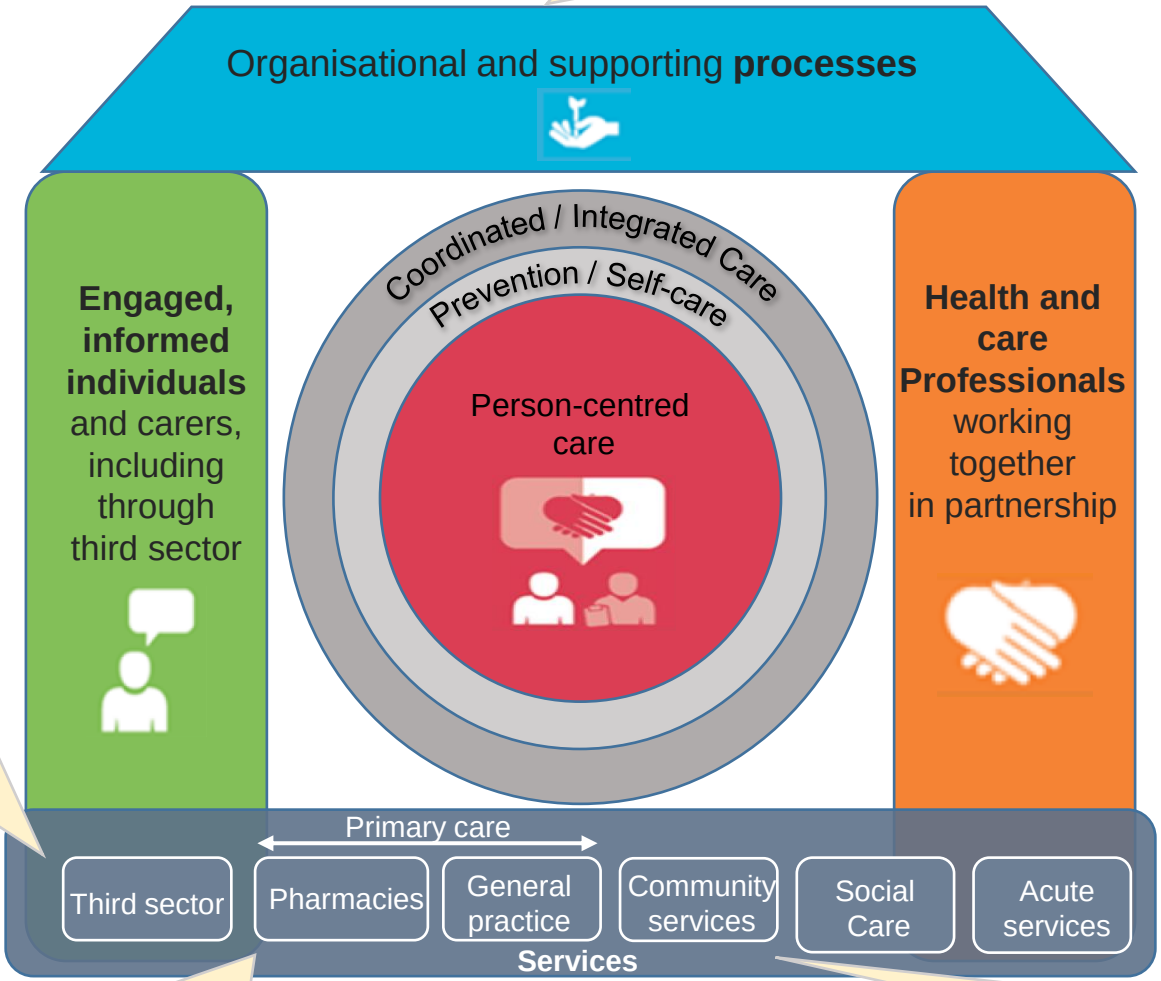
Our vision: A culture of health with empowered citizens

There will be better use of technology, diagnostics and medicines

Both investment and payment innovation will be required

The whole system will work to help people stay well and manage their health better

Staff will increasingly work across care settings and organisational boundaries



Person-centred care plans will be in place to help people stay in control of their long term condition

There will be quicker access to specialist advice when required

People will stay in hospital shorter amounts of time

People will only travel to hospital when it is absolutely necessary

Self-care examples

Scheme	What is working well
Newham self-management support programme	• This scheme is a new health coaching and signposting service provided by community pharmacists, supported by primary care. This intervention supports people at moderate risk of hospital admission to develop a well-being plan and provides them with the tools, skills, confidence and support to enable and encourage them to take a more proactive role in managing their own health and wellbeing
Newham telecare monitoring	• By using telecare monitoring of people at high risk of hospital admission, Newham has seen a 20% reduction in emergency admissions and a 14% reduction in planned admissions
Waltham Forest Wellbeing at Home	• The WB@H service provides short-term non-clinical support to link vulnerable and socially isolated people at risk of unplanned admission to hospital with a range of services. Support is limited to 12 weeks. Patients have reduced their healthcare usage for up to six months after interventions. Potential net savings are £400k a year
Waltham Forest pharmacy self-care	• The CCG has just commissioned packages of self-care from trained local pharmacists

Self-care examples

Scheme	Description – what is working well
Tower Hamlets Assistive Technology	Better Care Fund-supported Assistive Technology (AT) Team provides training and support to social care and health professionals, and pilots and implements new initiatives and projects. In the last six months there were approx: • 275 requests • 295 installations of equipment • avoided costs of £132,000
Social prescribing in Tower Hamlets	331 referrals in six months. Currently receiving 100+/month. • Referrals to 29 local services. 70% of referrals were to health programmes, 20% to services for vulnerable people and 10% to employment support, adult learning and/or welfare • 70% said it made a significant improvement in their lives, 75% said that it had resolved or partly resolved the issue, 70% said they would not otherwise have accessed the service. 95% said they would recommend the service to others

Elective surgery

Case for change and benefits

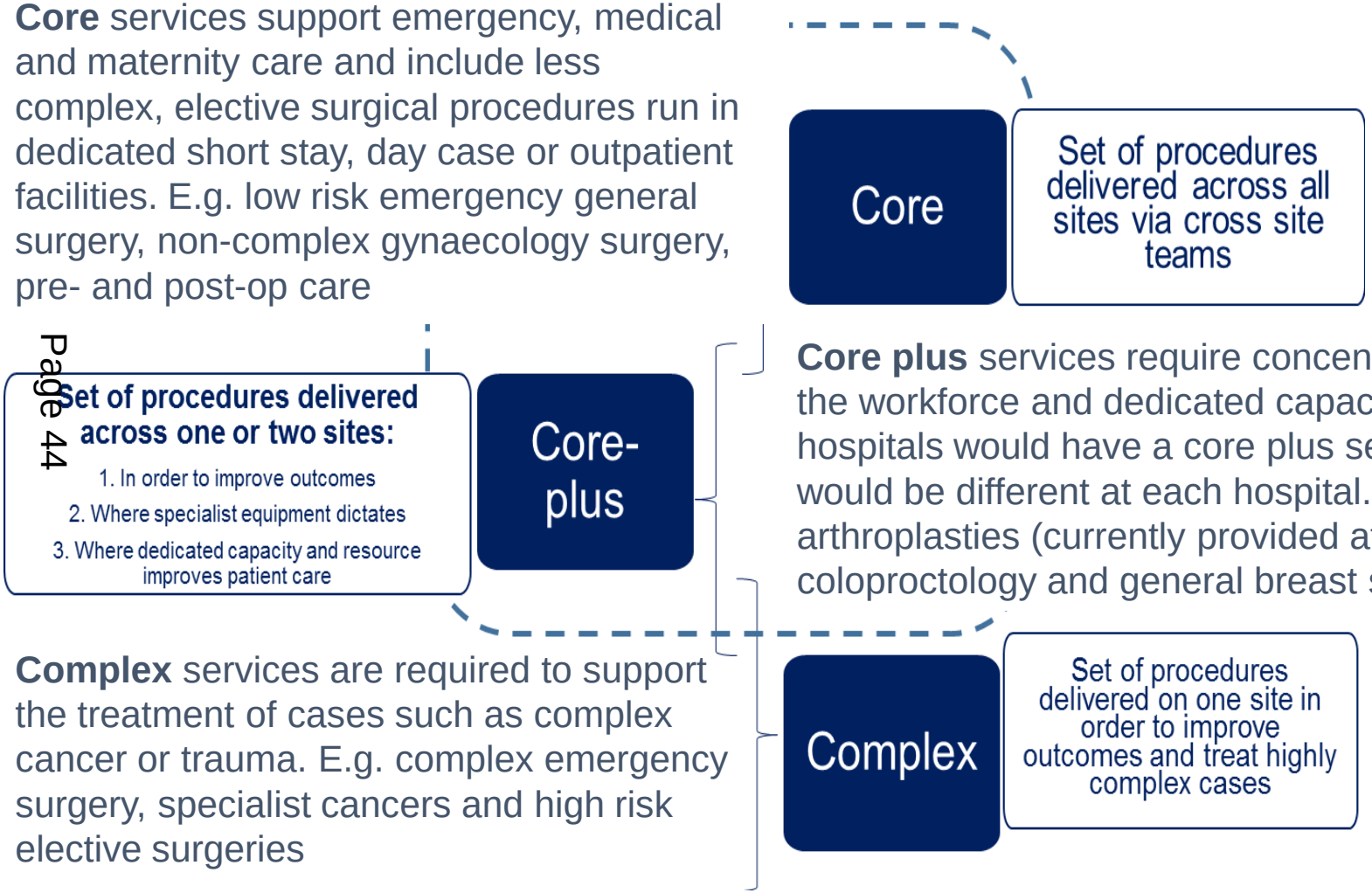
The CQC has inspected all three main Barts sites and found quality issues that need to be addressed.

- **Low volumes for some procedures:** Evidence shows a positive correlation between numbers of patients treated and health outcomes
- **Cancelled elective procedures:** The Royal London in particular can't properly separate emergency and elective services due to unpredictable emergency requirements and high bed occupancy. In some specialties up to 20% of elective operations are cancelled. This is inefficient, risks the spread of infections, wastes patient journeys and causes distress
- **Resource constraints:** Chronic staff shortages and the cost of maintaining specialist equipment means that providing every type of operation at all hospitals is wasteful and inefficient.

Surgical hubs would help address these issues and: further reduce lengths of stay; reduce waiting times; support robust A&Es at Newham and Whipps Cross; and enable work to be repatriated back from independent providers. Pre- and post-operative services would be at local hospitals

Defining surgical hubs

Core services support emergency, medical and maternity care and include less complex, elective surgical procedures run in dedicated short stay, day case or outpatient facilities. E.g. low risk emergency general surgery, non-complex gynaecology surgery, pre- and post-op care



Core plus services require concentration of the workforce and dedicated capacity. All three hospitals would have a core plus service, but it would be different at each hospital. E.g. arthroplasties (currently provided at Newham), coloproctology and general breast surgery.

Complex services are required to support the treatment of cases such as complex cancer or trauma. E.g. complex emergency surgery, specialist cancers and high risk elective surgeries

Co-designing surgical hubs

We want to work closely with service users to develop surgical hubs that will best meet their needs. For each hub proposal, we plan to have:

- Weekly core team sessions:
  Involves the core team reviewing progress of deliverables
- Fortnightly working sessions:
  Involves the core team and others designing a specific surgical hub. Will include representatives from different levels of participating organisations as well as service users
- Community engagement events:
  Used to present work already done, present proposals for new surgical hubs and gather feedback

Mythbuster – hospital stays

There is some concern about day-case surgery and shorter lengths of stay in hospital for vulnerable (often old) people, if there are not sufficient community services. This also applies to the next topic regarding our aim to reduce the number of inpatients.

We accept that we need to improve community care and work with social services, however it is worth bearing in mind that when an older person comes into a hospital bed: it restricts their mobility – resulting in muscle weakness and immobility; increases their exposure to infection; can cause incontinence; increases confusion; increases the risk of falls; and reduces appetite.

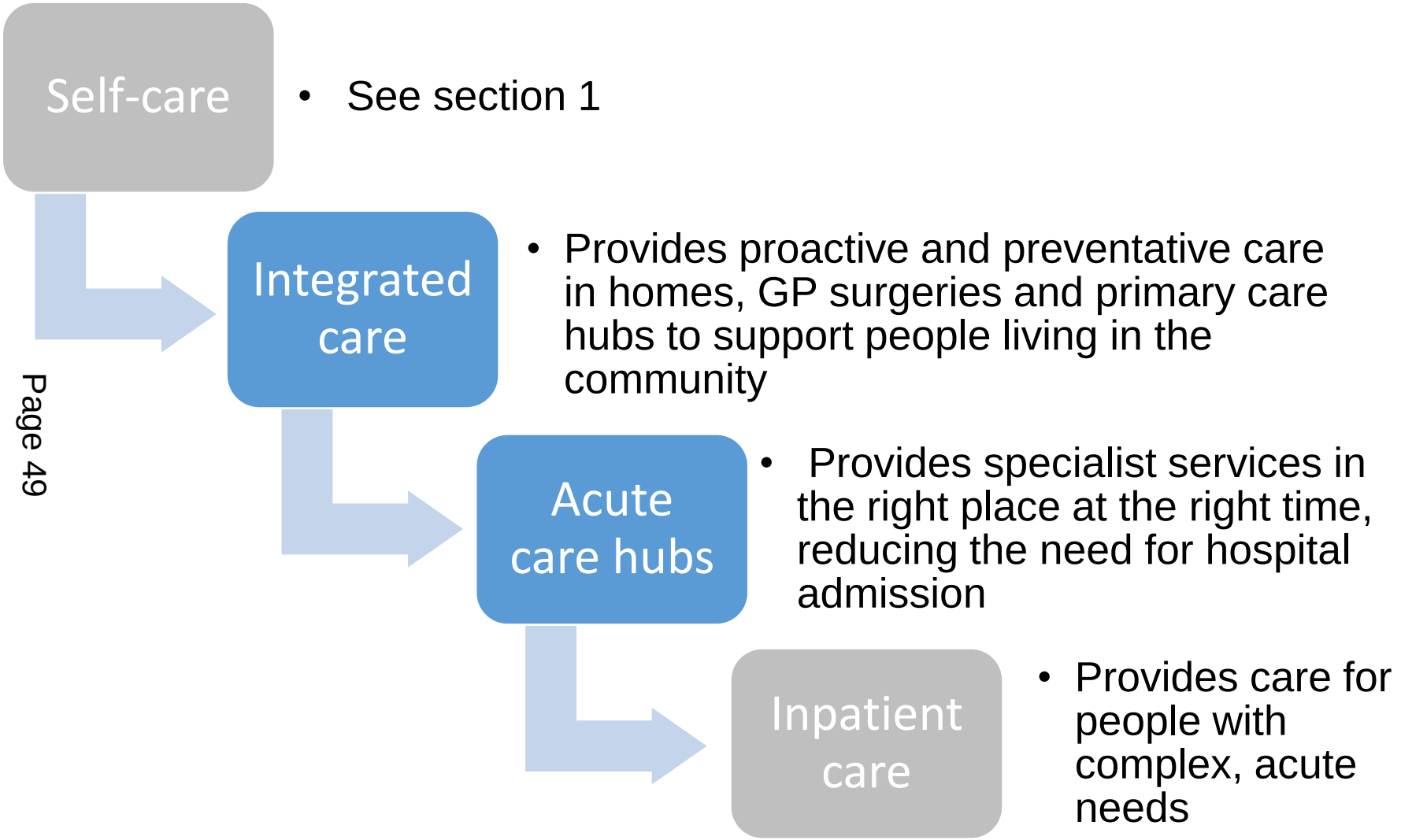
- *Ten days in hospital leads to the equivalent of ten years' ageing in the muscles of people over 80*
- *48% of people over 85 die within one year of hospital admission*

Elective surgery - example

Scheme	What is working well
Barts Health Orthopaedic Centre (Newham)	• Increasing joint replacements from 100 to 600-700 a year. • It has one of the shortest lengths of stay (LOS) in the country. LOS for hip and knee replacements have reduced from around one week to 2-3 days • The last CQC inspection rated the centre as an area of outstanding practice: *"The Centre's environment design, layout, equipment and integrated care with members of the multidisciplinary team was recognised as meeting patients needs and delivering excellent outcomes. The Centre supported new pathways of care and achieved one of the best day care rates in the country.* *"ward and theatre environments were visibly clean and maintained. Patients told us they were satisfied with the standards of cleanliness. At The Gateway Surgical Centre, one patient told us, "It is absolutely spotless here."* *Patients told us, "I've chosen to travel here rather than use my local hospital, as it has an excellent reputation for hip surgery," and "The care on this ward is outstanding."*

Movement of services and patient journeys (acute patient pathways)

Acute care hubs and ambulatory care



Integrated care – examples

30,000 integrated care plans. Developing 35,000 more this year for those at medium risk of hospital admission. The projected savings from integrated care over the next five years are between £4.2million and £6.6million.

Scheme	What is going well?
Blood pressure and cholesterol management: Newham and Tower Hamlets	Patients who have had a stroke, have diabetes or have heart disease and need their blood pressure and cholesterol managed benefit from one of the country's best services in Tower Hamlets and one of London's best services in Newham
Rapid Assessment, Interface and Discharge	This service supports specialists in acute settings working with people with mental health conditions. Mental health (including alcohol and dementia) is the third most common reason for emergency hospital admission
Waltham Forest heart failure test	GPs can now test for heart failure using B-type Natriuretic Peptide testing , saving patients a trip to the hospital

Integrated care: future diabetes care

Harjit Singh is 59, he has type 2 diabetes controlled by tablets and insulin.

He has high blood pressure, heart and mobility problems which have led to the development of leg ulcers.

He has regular appointments with his GP and nursing team and requires repeat prescriptions.

Harjit doesn't fully understand his condition and finds it hard to eat healthily. He lives on his own but his daughter cooks for him on a regular basis. She doesn't exactly understand her father's requirements.

Current treatment

- On Fridays, Harjit travels 0.75 miles to his GP practice to see the nursing team based at his practice one day a week.
- He has his blood pressure and sugar levels checked and his dressings changed. Once a month he also sees the podiatrist to have his feet checked.

- Every third Tuesday, Harjit travels to his GP practice so his GP can check his blood is clotting correctly and to change his medication if necessary, otherwise Mr Singh could suffer a stroke.
- He collects his prescription from the pharmacy 0.25 miles from his home.

Currently Harjit travels around 9 miles a month to see healthcare professionals

New treatment

Harjit is healthier and more satisfied with his treatment

- The primary care hub offers Harjit health and wellbeing advice including access to a dietician. He and his daughter have been on a diabetic education course so they better understand his illness and know how to eat more healthily. This has increased Harjit's confidence and ability to manage his diabetes.

- Harjit has been put in contact with other diabetic users and he now attends a fitness class which is improving his mobility, his ulcers and his health.
- All of Harjit's healthcare professionals have access to his medical records which means he doesn't have to repeat his medical history at every appointment. If he has any questions or concerns, he can ring his GP or nurse.

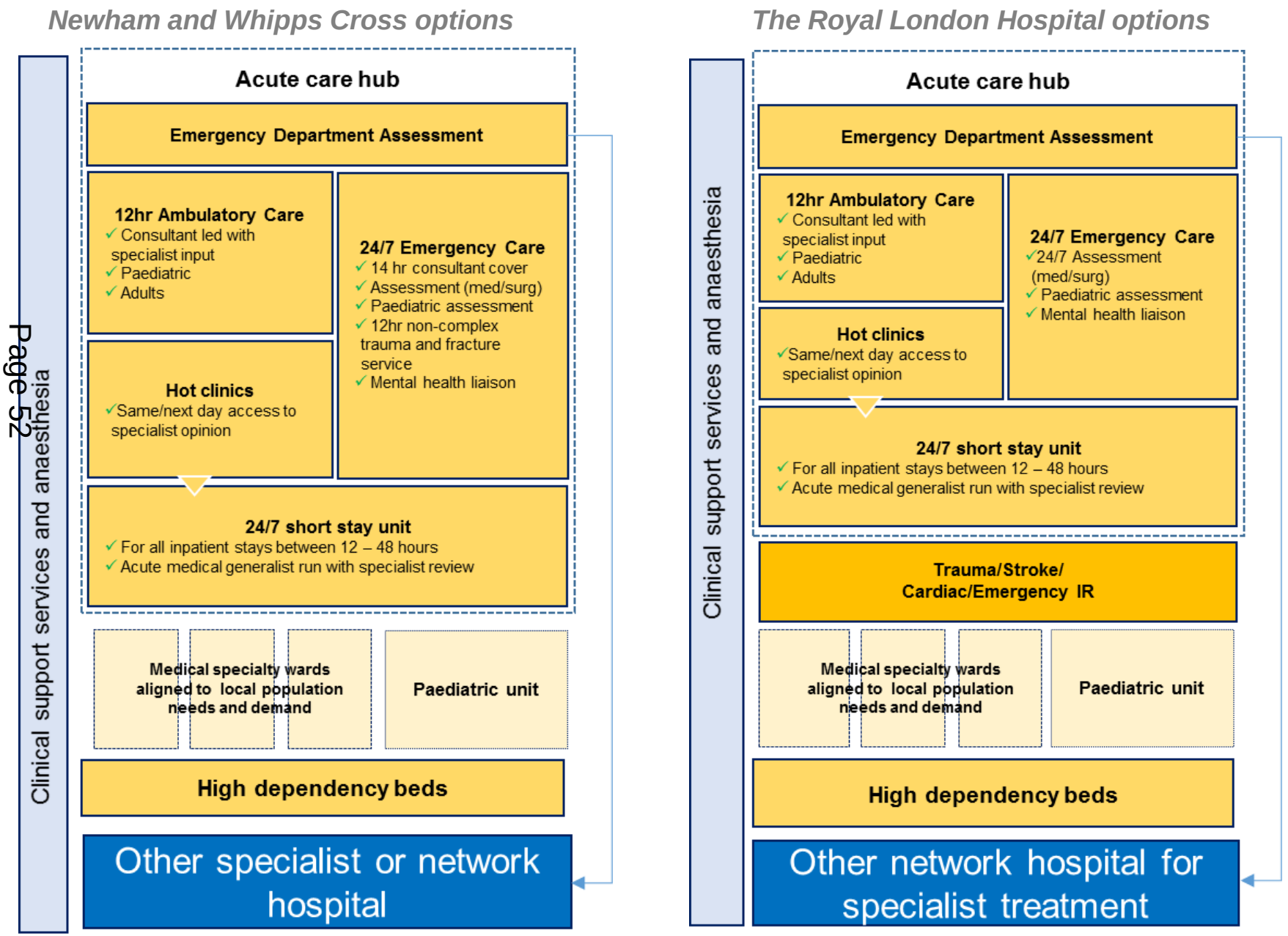
Harjit finds healthcare more accessible

- Harjit has been taught to take his own blood pressure which he now does from home.
- He can get his anti-coagulant blood tests and dosage adjusted at his pharmacist.

- He travels once every three months to the hub (which is a mile from his home) as he can book appointments to see his GP, nursing team and podiatrist on the same day because they are all based there full time.
- His nurse comes to visit him to change his dressing and check that his blood sugar levels are correct.

On average Harjit now travels less than a mile a month to see healthcare professionals

Acute care hubs and ambulatory care

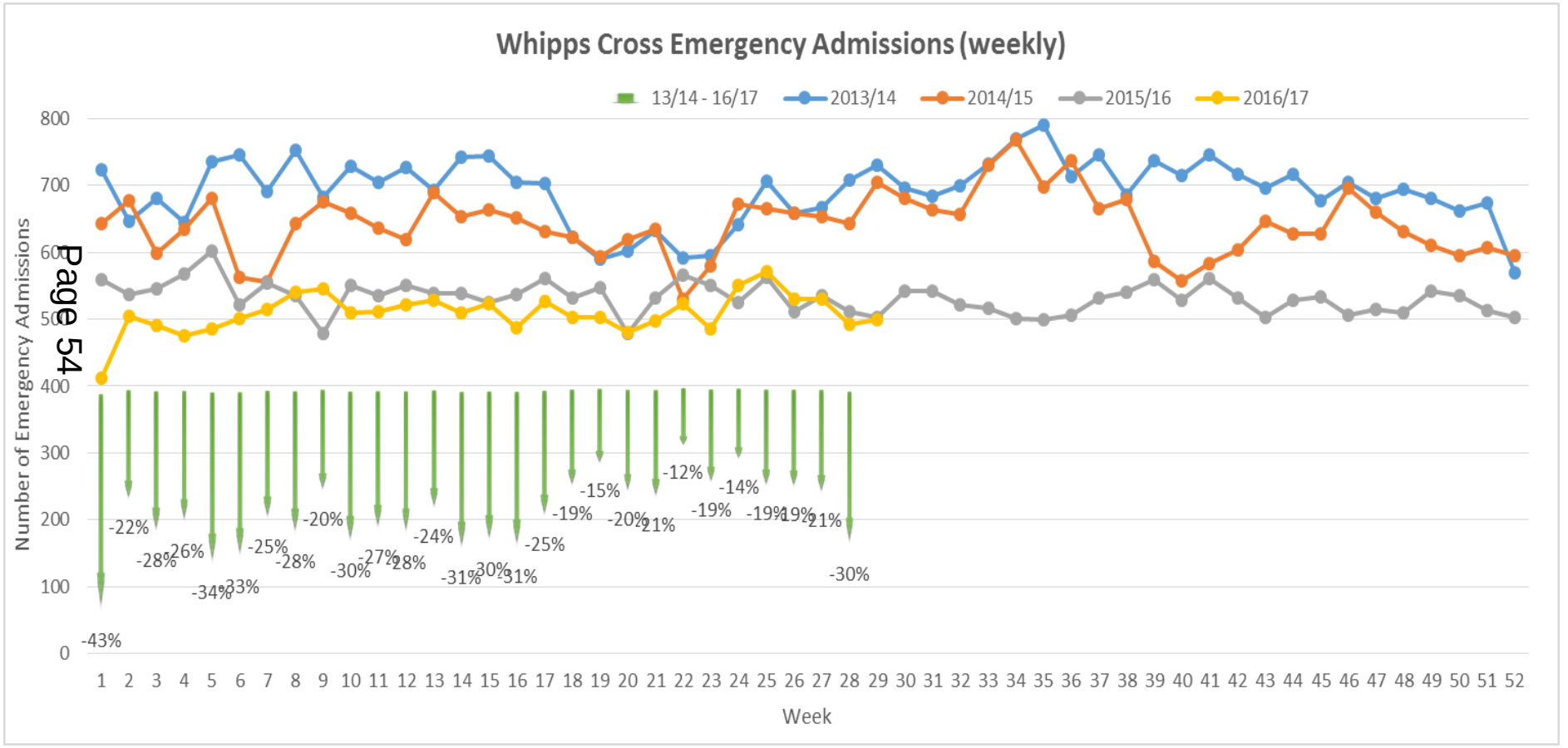


Whipps Cross: ambulatory and acute care

Scheme	What is going well?
Emergency gynaecology unit	Provides one-stop diagnosis. This has halved associated emergency attendances and reduced waiting time breaches by 80%
Ambulatory care	Pilot in 2015/16 recorded 4,410 visits: • Of the 2,636 visits that were not follow-up appointments, over 700 admissions (24/week) were avoided • In Royal London a similar scheme is avoiding 28 inpatient stays a week. Newham already has a ambulatory scheme which has avoided 90% of admissions with projected lengths of stay under one day • In the Whipps Cross pilot, there were noticeable improvements in A&E performance and patients scored (out of a max 5) ✓ 4.9 for 'Did the unit serve your needs' ✓ 4.6 for 'Would you attend again'

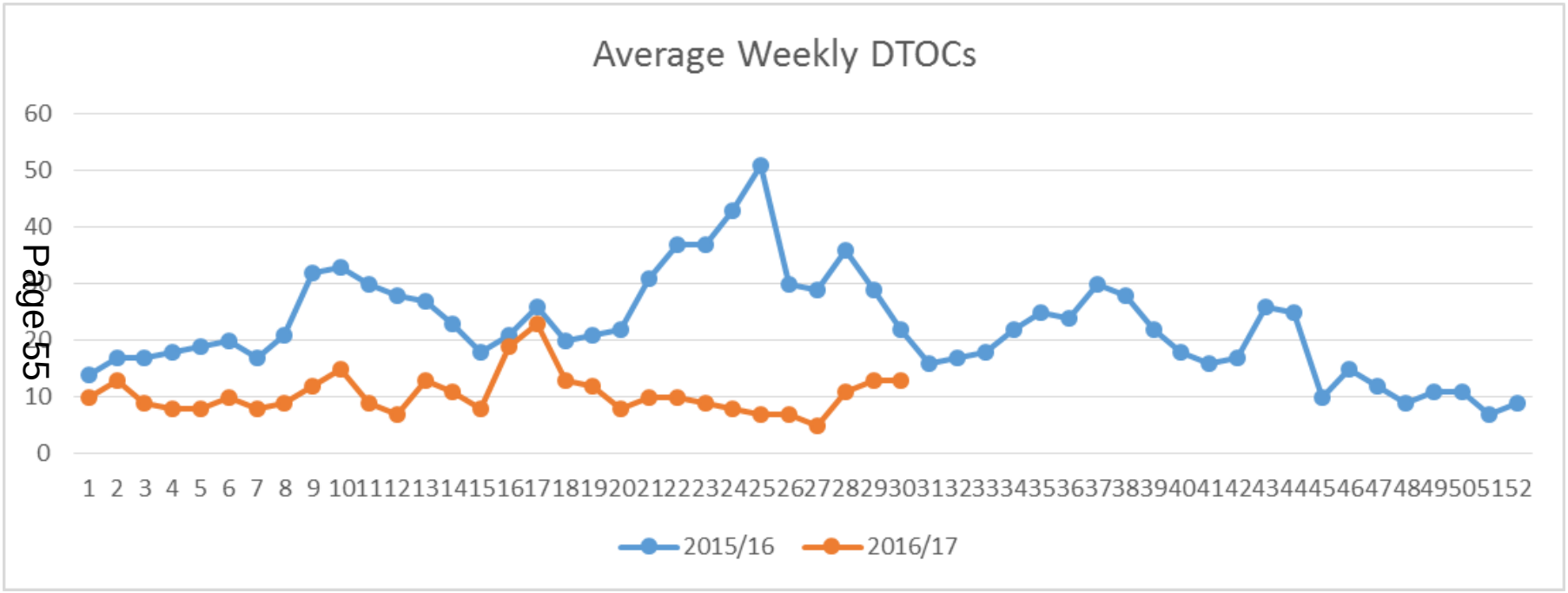
Whipps Cross: reducing emergency admissions

25% reduction in emergency admissions over three years



Whipps Cross: reducing unnecessary length of stay

60% reduction in Delayed Transfers of Care (DToC) in 2016/17



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