Transforming Services Together

Strategy and Investment Case
About Transforming Services Together

The Transforming Services Together programme was established in September 2014 by Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups to deliver high-quality, safe and sustainable services for the population of East London.

It proposes system-wide transformation and partnership working to a degree not seen before in this region. The CCGs are working with their main hospital services provider, Barts Health NHS Trust and a range of other organisations, as well as members of the public, patient and public representatives and staff are also involved:

- Neighbouring CCGs – in particular, City and Hackney CCG, Barking and Dagenham CCG, Havering CCG and Redbridge CCG
- Homerton University Hospital NHS Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Local authorities (including public health teams) – in particular London Borough of Newham; London Borough Tower Hamlets; London Borough of Waltham Forest; London Borough of Redbridge
- NEL Commissioning Support Unit (NEL CSU)
- NHS England (NHSE) – responsible for specialised commissioning
- Trust Development Authority (TDA)

To find out more, please visit www.transformingservices.org.uk
About this document

This document brings together the collective work of the Transforming Services Together programme. Ambitions and proposals are set out, along with the context to a series of detailed initiatives which are the core of the Transforming Services Together programme.

Over 300 people have been involved in developing this document, including clinicians, nurses, midwives, pharmacists, primary care and social care staff and managers. Over the coming months we will be testing our ideas with staff, local communities, partners and patient representatives, through meetings, workshops and other methods of engagement.

To make your views known, please contact the Transforming Services Together team.

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Whilst we will continue to engage throughout the development and implementation of any proposals, we will be finalising the Strategy and Investment Case in June 2016, so if you would like to contribute to this, we need your comments back by midnight on 22 May 2016.

There are three parts to this strategy

Part 1: A summary which includes a questionnaire to make your views known

Part 2: This document

Part 3: A detailed analysis of each of the 13 proposed initiatives

Assumptions and terms used in this strategy:

- Population growth is from the GLA (SHLAA-capped model 2013 release).
- The workstreams used the best available local data on current performance and activity from local providers and national sources. Different sources, coding, submission practices and time periods means there are some limitations to this data.
- **Emergency care** is where a patient’s life or limb may be at risk and hospital care may be required; **Acute care** is normally provided in hospital, where the patient requires 24/7 nursing care and it takes place under the care of a hospital consultant; **Urgent care** is where a patient may require treatment for an illness or minor injury rapidly but it is not life or limb threatening.
- We use the term emergency department rather than A&E.
- **East London** is the term we use for the boroughs of Newham, Tower Hamlets and Waltham Forest. This is the focus of this strategy. **North east London** (NEL) is the term we use for the boroughs of Newham, Tower Hamlets and Waltham Forest plus the City of London and the boroughs of Barking and Dagenham, Hackney, Havering, and Redbridge.
- The ‘we’ referred to in this document relates to the signatories of the foreword, and the organisations they represent.
- We can plan for the future, but political, environmental, economic, social and technological changes make it uncertain. We will continue to discuss and reshape our ideas and proposals in line with new knowledge, policy and developments.
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1. The case for change

1.1 Our population and our services

The changes described in this document build on national and regional guidance\(^1\) and local work to develop the Transforming Services Changing Lives *Case for Change*\(^2\). These document the scale of the challenge facing East London health and social care services.

- Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest will probably grow by 270,000 – the size of a new London borough. More births are anticipated and there is a need to plan for the increased demand on services. As people live longer, so their health and social care needs also increase. Hospitals and emergency departments already face unprecedented demand for services. Patient expectations are increasing.

- There is a high level of population movement into and out of East London boroughs. For example, Tower Hamlets has 281 people moving in and out of the borough each year per 1,000 population\(^3\). This can cause difficulty in providing continuity of care. At some emergency departments as many as 30% of those attending are not registered with a GP. The urgent care system needs to be fixed to ensure patients are seen in the right care setting for their needs.

- Life expectancy in our boroughs is amongst the lowest in England, but that is more to do with environmental factors and deprivation in the area than a reflection on the quality of healthcare. Preventing ill health; better management of conditions by care providers before they become severe (and providing support for patients to self-care); and treating people holistically by looking at their physical and mental health needs together is essential to the long term future of healthcare.

- The quality and availability of some services could be improved. Emergency department attendances are high, which indicates issues with access to, or experience of, primary care or other services in the community. Too many patients are being readmitted to hospital as emergencies within a month of being discharged; and we are not meeting all of the London quality standards in our hospitals.

- Integrated care for people with long-term conditions needs to be provided and new, more efficient and effective care pathways need to be designed so that patients experience more individual care. More services need to be provided in the community, but some services and specialties also need to be brought together in the same place when there are clear advantages to patients in doing so.

- Whipps Cross Hospital was inspected by the Care Quality Commission (CQC) in November 2014 and received a rating of inadequate. As a result, Barts Health NHS Trust was put into special measures. Later inspections of Newham and The Royal London hospitals also resulted in ratings of inadequate in May 2015. The special measures regime is supporting the implementation of improvement plans to address immediate issues across the three main hospital sites. The Transforming Services Together programme aims propose initiatives that support improvement.

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\(^1\) E.g. the *NHS Five Year Forward View* and London Health Commission: *Better Health for London* (2014)
\(^2\) [www.transformingservices.org.uk](http://www.transformingservices.org.uk)
\(^3\) Transforming Services Changing Lives *Case for Change* (2014)
1.2 The challenge to the estate

The *Case for Change* identified a number of challenges associated with the variable capacity and quality of the current NHS estate across East London. Since then a more comprehensive asset register has been developed in conjunction with NHSE, the CCGs, providers, NHS Property Services and Community Health Partnerships.

Our current estate – the challenge

1. We have a large number of buildings across East London that belong to, or are occupied by the NHS. In total, we have 164 across primary care of which 66 are in Newham, 50 in Tower Hamlets and 48 in Waltham Forest. Our providers also have a large number of properties, with Barts Health occupying around approximately 450,000 square metres (sqm), North East London NHS Foundation Trust (NELFT) about 30,000 sqm around Waltham Forest⁴, and East London NHS Foundation Trust (ELFT) about 45,000 sqm around Newham and Tower Hamlets.

Most importantly, we have mapped the sites into the NHS England-prescribed SHAPE tool, which combines various inputs (such as population growth, transport links and other factors) to visually support estate strategy development.

Tower Hamlets Primary and Community Care site profile and estate map⁵

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⁴ *NELFT Estate Strategy* 2014-2019 (page 13)

⁵ For all three maps, the numbers in circles represent where there is more than one facility in a particular location. This visual presents the majority of NHS sites; we know that some – such as certain individual ELFT and NELFT community sites – are not included in this data.
Newham Primary and Community Care site profile and estate map

Site profile
- 66 sites on NHS England Asset Register
- Approximately 65 GP practices
- Significant number (21) of small single handed GP owned sites (average list size of 3,470)

List size
- Total (known) list size across borough of 398,113
- Average list size in 2015 of 6,125

Waltham Forest Primary and Community Care site profile and estate map

Site profile
- 48 sites on NHS England Asset Register
- Approximately 45 GP practices
- 5 small single handed GP owned sites

List size
- Total (known) list size across borough of 293,258
- Average list size in 2015 of 6,665

Numbers in circles represent where there is more than one facility in a particular location. This visual presents the majority of NHS sites; we know that some – such as certain individual ELFT and NELFT community sites – are not included in the data.
2. The quality of our buildings varies considerably. We have some leading practice and high-tech facilities which are very new, such as the Royal London Hospital in Whitechapel, and the Sir Ludwig Guttmann Centre which are under five years old and represent significant investment in our region.

But a lot of our estate is of poor quality and needs further investment. Waltham Forest CCG has recently completed a survey showing that their premises are in a

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6 Total bed numbers provided here are the current establishment across all Barts sites; outputs of the TST model predict a slightly lower total figure due to the calculations being made on bed occupancy rates

7 The six facet survey forms the ‘core’ estates information required by NHS Estate CODE. The resultant survey will allow condition categories to be allocated to properties on a facet by facet basis together with a summary of remedial costs to bring each facet up to a safe and sound condition
varying condition across the borough with 63.6% of premises being condition A\textsuperscript{8} or B\textsuperscript{9} or above and 35.4% being condition C\textsuperscript{10}. This means that on some sites, a lack of short term investment may lead them to become unsuitable for patient care and some buildings create inefficiencies.

a. We estimate the total cost of critical maintenance across the three boroughs to be around £163 million, of which about £141 million is on Barts Health sites.

b. Whipps Cross Hospital represents the majority of Barts’ estates challenges, with about £80 million of critical maintenance needed on the site (70% of which is over 30 years old). In addition, the current location of the maternity suite is separate from the main facility. Any emergencies that arise must be handled by ambulance.

c. The total cost to bring all the primary care premises up to Condition B (and ensure properties in danger of falling into condition C, are retained in condition B) is estimated as £23 million. St James Health Centre, in Waltham Forest, is one of the sites that requires urgent work to rectify maintenance issues. The landlord, NHS Property Services, is planning a programme of £250,000 of essential works to keep the premises going pending a full redevelopment option on a nearby site.

3. We do not use our buildings as effectively as we should. For instance, there is c.3,000 sqm of empty space across the three boroughs’ primary care estate. This costs the CCGs, but is not occupied. We also know there are opportunities to increase the volume of activity that is delivered from the sites that are occupied. More work needs to be done to clarify the precise extent to which we can increase the utilisation of our estate overall (e.g. through increasing the opening hours or number of clinical sessions that are offered).

4. Our infrastructure does not encourage multi-disciplinary use of the same properties. Either providers consider them to be expensive and look elsewhere, or they are not fit for specialist services that would complement the existing care being delivered. For instance, the Sir Ludwig Guttmann Centre’s utilisation could have been increased by providing some of ELFT’s mental health services there, but its lay-out is not considered a safe place for ELFT’s patients to receive care. In addition, The Barkantine Centre has a total annual property charge of over £2 million, creating high service charge costs for providers, which is often unaffordable.

5. Our acute sites are broadly operating at, or close to capacity. Each of the Barts Health hospitals have experienced significant challenges over the past 12-18 months as demand for inpatient beds has continued to grow. This has contributed to poor performance against some key targets (e.g. A&E (emergency department) and 18 week referral to treatment times).

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\textsuperscript{8} Condition A: as new (built within the past two years) and can be expected to perform adequately over its expected shelf life
\textsuperscript{9} Condition B: sound, operationally safe and exhibits only minor deteriorations
\textsuperscript{10} Condition C: operational but major repair or replacement will be needed soon, that is, within three years for building elements and one year for engineering elements
The drivers for change

In order to define robust investment strategies, we also need to take account of the factors that will influence how the estate should be configured. The key drivers of change that will impact the estate include:

- the population growth. If we don’t change our health system this growth would translate into demand for an additional 550 inpatient beds – the equivalent of an extra hospital. We’d also have to invest heavily in our primary care and community estate to ensure the right facilities are available for the population as it grows
- changes at King George Hospital emergency department. This will drive additional demand, on top of the population growth, into Whipps Cross and Newham hospitals
- funding to deliver major capital programmes is limited. The NHS in north east London is under considerable financial strain, limiting its ability to deliver significant capital programmes. A coordinated, cross-system approach is needed to establish a robust strategy that will drive the right investments that are of benefit to the system as a whole, including any proposals for disposals to reinvest money
- delivering outpatient services in the community will require provision of generic (flexible) consultation/examination and treatment rooms, ideally collocated within primary care hubs.

1.3 The IT/informatics case for change

Delivering new technology can only be achieved if the underlying infrastructure is capable of supporting it. We have completed a review and have a clear understanding of the existing situation and any deficiencies. We plan to fix the basics before delivering more advanced, interoperable, services.

New ways of working must change the existing ‘diagnose and treat’ regime to ‘predict and prevent’. There is a need to focus on a more personalised and participatory health system, where treatments are based on likelihood of individual response and people are encouraged to take a more active role in managing and maintaining their own health and wellbeing.

Commissioners need to work together to deliver co-ordinated services for the populations they serve, supported by value and outcome-based payment arrangements. This requires information to flow more effectively across health and care.

Without a change to provide interoperable systems which share information and support the delivery of a single electronic health record (EHR) to all parts of the healthcare system at the point of need:

- we won’t eliminate waste – data sharing will be by slow and expensive paper records
- clinical benefits won’t be realised – the real-time availability of a single, shared (EHR) is essential to support ‘predict and prevent’
- financial benefits won’t be realised – integrated care planning and identification of the 20% most at risk of needing hospital admission may not be achievable. Care will remain as ‘diagnose and treat’ and hospital admissions will remain at (high) levels
productivity improvements won’t be met – for example urgent and emergency care pathways will not be supported without integration of systems and the availability of a shared EHR.

In East London, we are already delivering a shared view of patients’ EHR using Cerner’s health information exchange (HIE) in conjunction with HealthCare Gateway’s Medical Interoperability Gateway (MIG). However this provides a limited view of the EHR and is only available to hospital-based clinicians in Barts and GPs using EMIS, the leading primary care IT system. There is no sharing of data for community, mental health or social care; and individual care plans, critically important to our most at-risk patients, remain paper-based.

Without continued work this shared view will remain limited and read only, and will not be connected to any of our neighbouring providers or across the rest of London. The shared data cannot be used for the systematic review and risk analysis required to support population health and integrated care.

We also need to ensure that new services (such as the shared care record) are viewed and used. This is already a significant problem and will continue as new functions are made available. For example, whilst the functionality is enabled to allow discharge summaries to be sent from Barts Health directly to the GP systems in Waltham Forest, it is only effectively used in 20% of practices.

The drive to deliver a shared care record is supported by NHS England which is advancing the connectedness of EHRs and the interoperability of health information technology. This has been identified as a key aim and articulated in a number of key reports and in the Five Year Forward View which made a commitment that, by 2020, there would be “fully interoperable electronic health records so that patients’ records are paperless”11,12. Achieving this goal will support decision-making, reduce acute admissions and help to transform access to services. It will support more efficient and effective care, enable new models of primary and urgent care and lead to a continuously improving health system that empowers individuals, provides individualised health plans (leading to customised treatment), enable integrated care and accurate risk stratification in real time and support the management of long term conditions.

NHS England has requested all CCGs develop a digital road map to set out their plans for a more connected and paperless system and the TST programme articulates how East London’s health and social care providers will achieve this.

At a London level:

- the Healthy London Partnership13 has created a programme of work which focuses on creating the vision for connecting Londoners and health and care providers to allow for real time access to records and information.

- NHS England London is working with individual CCGs to define how they can link together to share information outside of their local infrastructure and the East London CCGs need to be part of this wider delivery in order to generate benefit for their patients.

13 https://www.myhealth.london.nhs.uk/healthy-london/interoperability
1.4 The workforce case for change

There are significant workforce challenges in East London; building a sustainable workforce is a key component of all redesign initiatives. As well as identifying the growing population, increasing population and financial pressures, we know that that around 70% of our budget is spent on staff, meaning that we will need to use our existing workforce more efficiently.

Dealing with future pressures will require the recruitment of a sufficiently skilled and flexible workforce with a strategy to retain and motivate staff to support improvements in quality and patient experience. This should include support of a clinical community that welcomes change and works together to find solutions to difficult problems and the development of new roles and different ways of working.

There needs to be changes to the way the East London workforce is structured and managed. We have to act in a concerted way to ensure the future viability of the workforce and delivery of a high quality service for our population.

The challenge

Providers have retention problems and high turnover rates

The average turnover rate of staff in East London providers is 15%, the equivalent of around 2,800 Full Time Equivalent (FTE)\(^\text{14}\) staff leaving the hospital providers every year. This proportion is higher than the 10.1% seen across the Health Education North Central and East London (HENCEL) area\(^\text{15}\). Between 45% and 72% of staff go on to work at another NHS provider, but at least a quarter leave NHS employment.

There is significant variation in turnover across Barts Health sites (amongst medical, nursing, allied health professional (AHP) and scientist roles), ranging from 15% at the Royal London to 31% at Mile End Hospital. 32% turnover rates were seen in Barts Health’s non-hospital workforce in the year to May 2015. As described in the overleaf graph, within our Mental Health and Community providers, turnover rates are 16.4% and 15.6% for East London Foundation Trust and North East London Foundation Trust respectively.

The number of paramedics leaving London Ambulance Service (LAS) increased dramatically between 2011/12 and 2013/14. LAS had around 600 vacancies (particularly paramedics) by April 2014 when turnover was 7.9% and this rate increased to 9.5% by April 2015 (18% for paramedics). LAS identify a range of reasons for the retention problem, but there are common themes of affordable housing, transport costs and the costs of further education.

Providers are not able to recruit to fill their current budgeted establishment, putting pressure on existing staff

All local providers have gaps between their projected staff numbers needed to deliver services, and numbers of staff in post, putting pressure on the workforce and impacting on their ability to deliver high-quality services. Without adequate numbers of staff, providers cannot deliver safe, effective care. For instance there was a 13% gap\(^\text{16}\) in nursing roles in 2015 across all hospital providers (a shortfall of around 730 FTE nurses). There was a further gap of around 250 FTE in other non-medical roles; predominantly physiotherapy and occupational therapy roles. At Barts Health there was a gap of 100 FTE in all medical roles.

\(^{14}\) Full Time Equivalent = full time employees plus part-time employee proportions aggregated together

\(^{15}\) Health and Social Care Information Centre workforce statistics July 2015 www.hscic.gov.uk

\(^{16}\) Shortage of staff compared to the full complement
(55 short in surgery, 27 short in acute medicine, 10 short in emergency medicine, and eight in other specialties) leading to some hospitals struggling to meet the London quality standards for consultant cover in emergency departments.

**East London trust turnover rates at 31 May 2015**

![Chart showing turnover rates for different trusts](chart.png)

*Source: HENCEL*

Forecast GP retirement rates, coupled with GPs wanting to reduce their workload and a lack of training, means that primary care will struggle to cope in its current form.

High proportions of the GP workforce are at, or are approaching, retirement age. In Newham, 38% of male GPs are aged 60 and over. In Waltham Forest the figure is 32% and in Tower Hamlets it is 12%. Many of these GPs want to reduce the hours that they work. Almost 30% of GPs in Newham wanted to reduce their workload over the next five years. To add to the problem, 6% of Newham's male GPs are single-handed practices, meaning that they do not have direct colleagues to whom they can hand over their workload.

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

![Chart showing male GP headcount by age](chart2.png)

*Source: Health and Social Care Information Centre (HSCIC)*

To deliver the forecast increase in activity in the existing workforce model we need an extra 125 GPs in five years’ time and 195 in ten years’ time in addition to today’s GP workforce.
This will be impossible given the national shortages and high retirement rates. An additional 30 practice nurses will also be required and there is a recognised workforce shortage.

There are also a number of skills shortages. For example, only 31% of the capital’s GPs believe they have received sufficient training to diagnose and manage dementia\(^\text{17}\) 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\(^\text{18}\).

**Sickness absence is high in some parts of the NHS and increasing**

In our region, sickness rates are similar to pan-London absence rates and vary between 3-4%. However, this masks variations, for instance: a higher level of 6% in clinical service (scientific) roles, 4-5% among nurses and a lower level of around 1% in medical staff (doctors); a 6% sickness rate at Newham Hospital and 3% at the Royal London; and an increasing proportion of staff on long-term sick leave at LAS in 2014/15.

**The drivers and opportunities for change**

**The high cost of living, perceived low pay and work-related stress contribute to high turnover and absenteeism**

Assuming the salary needed to live in London is £30,800\(^\text{19}\) (based on minimum income standard for London), a large proportion of lower band salaries (all staff in posts below a band 5, most staff in band 5 and some in band 6) fall below this threshold.

One consequence of the high cost of living is that people have to live further away from work (40% of the East London workforce live more than ten miles from their place of work and the average travel distance is 15 miles). The average annual travel cost is £2,378.

Dissatisfaction with pay across providers is also a consistent theme\(^\text{20}\).

This disproportionate effect on low paid staff may explain the reason why the 13% gap in nursing FTEs across the area is not distributed evenly amongst the salary bands. The lower bands are disproportionality hard to recruit – there is an 18% shortage in Band 5 nurses (equivalent to 464 nurses) whilst the difference between establishment and staff in post for Band 8a and above is 18 FTEs above the establishment.

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\(\text{17}\) National Audit Office, 2009

\(\text{18}\) CHIMAT (Child Health and Maternity Partnership Fundamentals of Commissioning Health Services for Children, 2011)


\(\text{20}\) The proportion of staff who are dissatisfied or very dissatisfied with their salary: ELFT 37%, Barts 46%, Homerton 43%, LAS 75% and NELFT 48% (Source: HENCEL)
Establishment vs in post nursing staff (Barts Health, May 2015)

Staff surveys for East London’s acute, mental health and ambulance service workforce reveal significant proportions of staff suffering work-related stress.

East London staff suffering work-related stress in the last year

There is an understaffed, stressed workforce, which is rapidly losing skilled workers though retirement, sickness and resignations, and which is simultaneously facing a large increase in workload as those staff are not replaced. The health system has made some remedial interventions but they have proven to be an expensive solution.

There are significant local and national staff shortages for some specialist roles

GPs: The Kings Fund reported in April 2015 that ‘the rate of increase in the number of GPs has been dramatically outstripped by increases in the medical workforce in secondary care – a trend at odds with the ambition to deliver more care in the community’\(^21\).  

Emergency Medicine: There are national shortages in the supply of consultants in emergency medicine; theatre nurses; a range of trainees in emergency medicine; non-consultant, non-training medical staff in emergency medicine (including specialty doctors working in A&E); and paramedics. This means some hospitals struggle to meet the London quality standards for consultant cover in emergency departments.

Paediatrics: There are national shortages in key roles. The Royal College of Paediatrics and Child Health has shown that between 2011 and 2013, the community paediatric workforce declined from 1375 to 1245, a 9.5% drop; and their 2013 census showed that the number of paediatric consultants is growing too slowly to meet demand and that there are 86 vacancies.

“Despite long-standing ambitions to raise the level and range of community services provided, it is difficult to see any increases among key staff groups. Any such increases have been limited to areas with specific national targets.”

There are high levels of spend on agency staff

In order to fill gaps in the permanent workforce, and in the absence of skilled people who want a permanent role, providers use temporary staff. The average substantive salary of staff is £49,000. The average cost of a temporary member of staff is £67,000, a 38% increase. In 2015, temporary staff comprised 12.4% of all FTEs in East London, but 16.3% of the cost. In 2014/15 Barts Health spent around £90 million on agency costs and the total spend on temporary staff across Barts, ELFT and NELFT was £146 million, a £40 million premium over the use of permanent staff. This situation is unsustainable.

1.5 The financial case for change

The NHS faces funding constraints and in East London it is estimated that there will be a £885 million financial gap across all organisations by 2021.

By March 2021:

- Commissioners have assumed a level of activity growth sufficient to meet expected demand and this has been estimated at £676 million for all providers.
- Cumulative funding allocations have been estimated at £327 million.

This means that there is the potential for an underlying deficit of around £349 million for the three East London CCGs before the impact of the TST programme.

Overall, the projected financial baseline deficit without implementation of the TST programme is in the region of £655 million for North East London organisations by 2020/21, of which £398 million is the responsibility of Newham, Tower Hamlets and Waltham Forest CCGs, plus Barts Health.

If we didn’t implement the TST programme (and in addition to revenue deficits), the East London health economy would need around £352 million of capital by 2020/21, rising to £1.1 billion by 2025/26. There is limited identified capital funding to support this level of spend.

22 www.nhsconfed.org/~/media/Confederation/Files/public%20access/Workforce%20workshop_urgentcare_March%202014/Health%20Education%20England.pdf

23 www.kingsfund.org.uk/publications/workforce-planning-nhs

24 Assessment Nov ‘15 ahead of CCG Allocations and Comprehensive Spending Review
The main components of the capital requirement are the need to:

- extensively reconfigure the Whipps Cross site
- build facilities on a new site sufficient to accommodate around 550 beds in order to meet demand growth
- address known estates backlog maintenance issues across the system

The method by which we have conducted our financial assessment are described in the end note.

1.6 If we don’t change...

- Patients will wait longer for their operations.
- Access to services will become poorer and many residents will continue to receive fragmented care.
- Mental health will continue to not have parity of esteem with physical health care.
- There will be later presentation of ill health to primary care due to capacity constraints.
- More patients will be seen in sub-optimal care settings.
- There will be more attendances at emergency departments for urgent care needs.
- Those at medium risk of admission to hospital will not be sufficiently supported with symptom control, self-care and secondary prevention.
- A high proportion of people will continue to be unable to die in the place of their preference, surrounded by their loved ones.
- Unnecessary stays in hospital due to the lack of availability of consultant opinion will continue.
- High lengths of stay due to lack of proactive ambulatory care models will continue.
- More women than necessary will continue to be cared for in obstetric settings which have higher intervention rates.
- Crucial care record information from different providers will not be available to care staff across the health and social care system resulting in sub-optimal clinical decision making.
- Patients will continue to be cared for in care settings that are not fit for purpose.
- Patients will continue to experience unnecessary trips to hospital.
- Patients will continue to experience unnecessary diagnostic testing.

In summary, the case for change is clear; to continue to provide safe, high quality and sustainable services in the future, organisations will need to work together to redesign care in a very different way.
2. Getting the basics right

The effective working of our estates, IT systems and workforce are central to delivering TST. Patients have told us that getting the basics right is just as important as really good clinical care. They want to be seen in well looked after buildings; they don’t want to have to tell their story to every member of staff that they meet because our IT is not joined up; they want staff to talk to each other and coordinate care, be caring as well as competent, to understand that little things make a real difference, and above all to recognise that every person is different.

The investment required to deliver change across these enabling areas will be significant. Recognising our financial constraints, it will be necessary to align closely with the pan-London capital allocation process to ensure sufficient funds are allocated to support the delivery of our strategy.

In addition to these enablers we need to continue to realise opportunities to work together to improve research, digital health and medical technology. This can build on the success of the Clinical Effectiveness Group at Queen Mary’s University of London to support continual improvement and the opportunities that the investments associated with the new Barts Heart Centre bring.

2.1 Estates

The ambition of the CCGs regarding the estate is for it to be flexible and fit-for-purpose. The estate will be actively managed and well utilised, with opportunities taken to share space with other services of benefit to the local public.

The Nuffield Trust (2014)25 has clearly stated that the traditional model of small GP surgeries is no longer suitable and plans should be in place to increase the scale of practices. This echoes strong messages in NHS England’s FYFV regarding delivering care in networks, federations and super-partnerships. The development of new infrastructure models can act as an enabler of new models of care by co-locating health, social care and community facilities in a single development.

Each CCG has been tasked with developing local estates strategies which were submitted in draft form, to NHS England at the end of 2015. A common approach has been adopted in each of the three CCGs to ensure the strategies are complementary. In addition to these borough-level strategies, an overarching East London estates strategy is being written that will draw all overlapping considerations together. This will be completed for submission to NHS England by the end of March 2016.

Principles to underpin estates transformation

Drawing on input from across the boroughs, we have set out the following principles to underpin the development of our estates strategy:

- Maximise the use of space in existing buildings before investing in new builds.
- Prioritise works to bring the existing estate to minimum condition B requirements.
- Ensure buildings meet all health and safety and statutory compliance requirements.

- Review the use of each building and reduce operating costs where possible.
- Utilise the combined resources and insight to ensure investment benefits the system.
- Deliver a flexible estate wherever feasible, to enable mixed use, to increase utilisation and to support changing needs.
- Actively work to remove factors that inhibit estate diversification (e.g. governance).
- Ensure good value for money and an efficient use of resources.

**Primary and community care estate**

There are practices of varying quality and suitability in each borough. In alignment with the primary care clinical strategy, our strategy for the estate is to drive towards a consolidation of practices to result in fewer smaller practices and a number of larger ‘hubs’, where a greater range of primary and community care services can be delivered in an efficient and modern setting. The smallest facility offering services will cater for 10-15,000 patients. Larger facilities for over 30,000 patients will host on-site minor surgery units, sexual health clinics, enhanced diagnostic services and community learning environments with access to nutritionists, health coaches and community groups.

A common model for defining hubs has been developed as defined below:

- **Primary care hub** – Consolidated GP practices (estimated 1,500 sqm). Centre Manor Park is a working example.

- **Primary care hub plus** – Consolidated GP practices plus outpatient/integrated social care facilities (estimated 1,500 – 2,500 sq m). These could house additional ‘office based’ specialties such as dermatology, rheumatology, neurology, additional obstetrics outpatient department services or integrated social care.

- **Multispecialty community hub** (estimated 2,500+ sqm). Mixed use centre housing local authority services (e.g. library, drop in centre), leisure facilities and primary care hub (or hub plus). Examples include the Greenwich Centre.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newham</strong></td>
<td>The under-utilised Vicarage Lane site in the north west of the borough would be a good location for a primary care hub with the potential for a second hub at the Sir Ludwig Guttmann Health Centre. Royal Docks ward could be a location for a third hub. There are discussions around a fourth hub to be considered at Centre Manor Park, and a fifth hub in the Canning Town development opportunity.</td>
</tr>
<tr>
<td><strong>Tower Hamlets</strong></td>
<td>The Prime Minister’s Challenge Fund is looking at the development of four locality hubs in Tower Hamlets. One hub in each locality which would provide care 8am-8pm and at the weekends with two GPs, a nurse, a healthcare assistant. The idea is to offer extra appointments. The hubs are likely be based in: St. Andrew’s Health Centre; Barkantine Centre; East One Health Centre; Blithehale Health Centre with an additional potential central hub in Whitechapel.</td>
</tr>
</tbody>
</table>
As the clinical strategies are scrutinised and developed, the estates strategies will be revised. In particular, the efficiencies planned by the primary care workstream (and the shift to pharmacy and self-care) are not yet fully reflected in the estates analysis.

**Acute care estate**

The Barts Health estate comprises some of the most modern and efficient estate in the region, as well as some of the worst. In some areas, there are significant challenges that will need to be overcome – with the potential need for major capital investment. Integral to these challenges is the limited financial flexibility the Trust has, due to its current circumstances and limited capital budget. Adopting a ‘whole-system’ approach to tackling the most significant challenges is therefore the most pragmatic.

The estates implications defined by each of the initiatives that impact on Barts sites will each need to be developed in more detail to confirm the precise requirements, costs and benefits they will deliver. Any requirements for capital investment will then need to be considered and prioritised against a large number of other requirements for capital across the area (for example, in the resolution of critical estate issues where a risk to patient safety will grow if nothing is done).

As Barts Health works to complete its overall strategy for sustainability, the implications on the estate will be taken into account. There are opportunities to consolidate and dispose of parts of the estate that are not efficient, and/or which are sited in locations where they hold considerable value to a residential or commercial market. Further analysis will be required to define how best this value might be extracted to support the delivery of sustainable and high quality acute patient care. Key issues being addressed at each site are:

**St Bartholomew’s Hospital:** Complete the phased redevelopment of parts of the site; consider the potential for disposal of poorly utilised or unsuitable parts of the site; develop and preserve elements of the historic, heritage aspects of the site.

**Royal London Hospital:** Complete the final phase of the New Hospitals programme (set up to deliver the new Royal London PFI building in the Whitechapel area), increasing the density (and therefore efficiency) of clinical services on the site; improve clinical co-location of key services; progress the sale and transfer of the old Royal London hospital to the London Borough of Tower Hamlets; progress plans to develop two further plots of land into a life sciences specialist centre, in collaboration with local education partners.

**Mile End Hospital:** As described in chapter 4 of this document (and in greater detail in part 3, section 12), there is an opportunity to better integrate acute, community, mental health and primary care services on the site. A system-wide strategy is required to define the most appropriate use of the site.

**Newham University Hospital:** Develop the Gateway surgical centre to enable greater volume of activity, in particular orthopaedic surgery.
**Whipps Cross University Hospital:** As described in chapter 4 of this document (and in greater detail in part 3, section 13), it is clear that there is a growing demand for acute service provision on the site, and a robust strategy is needed that defines how current and emergent challenges can be overcome. Working with local partners, a system-wide long-term strategy is required to define the most appropriate strategy for the site.

### 2.2 IT and informatics

The NHS collects vast amounts of data and we can use this much more intelligently, systematically and transparently. Developing joined-up information systems will support more effective, integrated healthcare.

We have invested significantly as a community in health information exchange(s) to provide early support for integrating care with shared information but also to build trust relationships between care providers. We want people to experience services that are truly seamless, with effective signposting, co-ordination of care and exchange of information supporting every patient’s journey. We want to enable better information exchange so that clinicians have access to key patient data to make decisions and reduce the risk of gaps and duplications in care. There are three broad areas of focus to ensure informatics enables the TST transformational changes:

1. **Single systems.** Ensuring that all the partners in TST use informatics to build a single approach, identifying and implementing the systems we wish to use to provide greater consistency and potential for information sharing across providers.

2. **Connectedness.** Utilising electronic information to make sure patients get the right care, from the right clinicians wherever they are managed.

3. **Use of big data.** The use of real time data to support care at the place and time of need, by providing system alerts and interventions across the care network and to deliver comprehensive analytical reporting, directly into the workflow.

We are delivering these objectives through a focus on four critical areas, which are:

1. **Infrastructure reliability and access.** To ensure that the infrastructure is up to the job of supporting reliable fast access to systems.

2. **Real-time, system-wide, shared electronic health records (EHR).** Wherever a patient is seen or a decision made in the health and care system, the appropriate data from every responsible health and care organisation must be available safely in a real-time structured view, embedded into the workflow of the local system.

3. **Advanced analytics; Insight to prompt changes (in both real time and aggregate form where needed) to treatment or care pathways should be derived by safely combining the data from every responsible organisation into a data service.**

4. **Patients’ involvement with their own EHR.** To ensure that patients get appropriate access to their record to help them interact with it.

The development of a real-time, system-wide, shared EHR is one of our specific initiatives described in chapter 4 of this document and part 3, section 10.
2.3 Workforce

TST seeks to address the challenges described in the previous section (case for change) through a range of initiatives.

Marketing the attractiveness of East London

It is important that we develop a compelling system-wide vision about East London as an attractive place to live and work to ensure that we can attract the brightest and best candidates. These messages will focus on the professional opportunities, as well as the personal benefits of living in a vibrant and diverse community. This vision and collateral could be used on local, regional and national recruitment drives.

Recruitment

Ensuring a supply of staff: to ensure we have the numbers and variety of staff that we need to deliver our plans, workforce planning should be an ongoing process; reviewing workforce demand and supply, and aligning it to the business planning process. This responsibility can be shared between local providers, as well as regional and national bodies for more specialised roles. As part of this process, we will engage with universities and other education providers to develop and deliver appropriate academic courses to encourage new staff groups (e.g. physician associates and advanced nurse practitioners).

Encouraging young people: in an effort to attract local young people to aspire to work in the NHS, we will work with local schools and education establishments at an early stage in students’ career planning process to build on the positive messages set out in our vision. We can also develop apprenticeships and internships which guarantee employment whilst in the final years(s) of training.

Together these initiatives should help develop a long term supply of local staff, enabling us to drive down the use of temporary staffing.

The development of physician associates is one of our specific initiatives, and is described in chapter 4 of this document and in greater detail in part 3, section 11.

Retention

Training and development opportunities: the development of clear and flexible career paths for various workforce groups will help highlight the career progression and earning opportunities in organisations and across primary, secondary and social care.

Other initiatives to consider include the development of federated training models across primary care, where a number of primary care providers come together for multi-professional placements, which benefit a range of workforce groups and promote MDT working.

Financial incentives: a range of financial benefits could be considered to ensure that we have the appropriate workforce in the face of shortages of particular roles. These could include pure financial incentives such as ‘golden hellos’ or ‘golden handcuffs’, or support with the high costs of London living and transport costs.

We could also consider key worker housing and transport strategies to incentivise hard to fill clinical workforce groups or introduce bursaries, student loans and other financial
support for potential graduates entering new or existing clinical professions. We will also explore the removal of perverse incentives such as high pay for bank and agency staff.

Other strategies may need to be considered in areas that are considered unattractive. For example, initiatives that prioritise the funding for doctors and nurses to work in hard to fill areas or initiatives to retain doctors considering retirement.

Flexible working options: offering flexible working could be attractive to candidates. We should investigate flexibility in:

- working hours – e.g. develop flexible contractual arrangements in order to accommodate the needs of a range of different groups such as young mothers, people with disabilities, single fathers and carers
- working patterns – e.g. develop nurse rotations to include placements in other care settings where appropriate; offer flexible options for those considering retirement, such as different working patterns to facilitate stepped retirement.
- local freedom for setting job roles and incentives – e.g. give primary care staff and commissioners flexibility to improve the attractiveness of roles to a workforce from outside of primary and secondary care

Communication: we must endeavour to improve job satisfaction through regular communication with our workforce. The emerging integrated provider networks will be encouraged to support communication, employment, education and training, as well the fostering of clinical leadership.

Improvement of workforce information availability, quality and analysis

There is a gap in workforce information that, if filled, could help the successful delivery of the TST strategy by providing transparency and improved accuracy of capacity forecasting. Initiatives could include a regular collection and analysis of primary care workforce data. Better information sharing about our collective workforce will help us understand staff gaps and help drive up the quality of the information we collect.

Local, regional and national approach

Implementing the workforce initiatives that are required to address recruitment, retention and MDT-working will need input at local, regional and national levels. Locally, it will be on an individual provider basis; regionally we would expect a collaborative approach between healthcare and non-healthcare providers, regulators and commissioners across health sectors to maximise efficiencies and outcomes and to influence national decisions; and nationally, statutory changes will need to occur in order to make some workforce groups and new ways of working attractive to both new staff and those already in post.

2.4 Organisational development

All the changes outlined in this document rely on staff co-creating, owning and leading the transformation process so its benefits are realised and sustained across the system. The Five Year Forward View recognised the importance of developing a modern workforce that is aligned with the changing health and social care needs of the population. It is therefore vital that we harness the expertise, skills and energy to transform and deliver care services.
Our shared understanding of opportunities and challenges is critical in planning and building readiness for system transformation. This includes supporting our staff community for change and, in particular our leaders at all organisational levels so they feel empowered and have the right resources to enact and sustain changes. Our focus on strengthening the local clinical and staff leadership is underpinned by the recent research and thought leadership by the Kings Fund advocating the move towards place-based systems of care26.

All organisations providing care need to be maximising the opportunities to work together and delivering care across organisational boundaries. We need to learn the lessons from the merger of Barts Health NHS Trust and fully utilising the opportunities that come from the recent strengthening of the leadership on each of the sites. We also need to recognise the opportunities presented by the new emerging models of care such as Primary and Acute Care systems (PACs) or Multispecialty Community Providers (MCPs) signalled by the Five Year Forward View.

Supporting health and care professionals in changing the way they work may require helping them to understand their changing professional identity and providing them with training, tools and resources. Organisations need to work closely with clinicians and the professional bodies representing them to achieve change. For instance:

- Primary care is facing unprecedented demand on services and a significant proportion of the services are provided by single-handed GPs nearing retirement age. For transformation to be successful, GPs and other primary care professionals need to be involved and engaged in redesigning the system and implementing new care and operating models in which multidisciplinary teams can operate efficiently.

- Transforming maternity services will require the staff to co-create the change to their own working patterns so the care provided is both safe and sustainable. This may challenge their current perceptions of how their roles add value to the expectant and new mothers and how they can facilitate patient-led care.

- We have identified the need to train staff across all settings of care in treating patients with dementia which can be done in a more time- and cost-efficient way if developed once for all local organisations.

Creating a safe learning environment, where innovation to create new models of care is encouraged and new ways of working can be tested is critical for staff to effectively contribute and shape the transformation process.

Staff need the skills to support the local population in changing their own behaviour so that people develop and maintain the healthy habits that can keep them well; and to change their approach to treating patients – moving away from paternalistic models of decision-making.

Strong leadership will be fundamental to sustaining our change efforts. Leaders need to be bold and courageous in breaking down organisational barriers so that all health and social care organisations can make best use of the limited resources they have.

Staff, partners, the third sector and all health and social care organisations can only build high quality, safe and sustainable services if we work as one system. The organisational development initiatives underpinning the TST draw on the conceptual framework for the learning healthcare systems and place a particular emphasis on developing a continuous

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learning culture. This will enable the transformation and ensure that the changes result in safe and sustainable services for our communities. A full estimate of organisational costs is contained in the description of each initiative (see Part 3).

The learning healthcare system

2.5 Working together

Delivering care in hubs across the health economy is central to a number of TST initiatives including surgery, urgent care and primary care (see chapter 4). New ways of working are proposed as part of this transformation:

- The MDT skill-mix operating at the front of our emergency departments will be broadened to include at least one registered practitioner and a healthcare practitioner. Where urgent care services are delivered, patients will have access to a prescriber so that they can resolve a much broader range of conditions.

- Collaborative working will also operate virtually in the community, with GPs, pharmacies, dental and community health and social care services connected by interoperable IT systems, working together to provide an integrated urgent care response, closer to where people live.

To achieve success will require close alignment of all the described enablers, for instance:

- New roles. The integrated care programme has already seen the development and introduction of some new roles, such as the care navigators, who act to co-ordinate the planning and delivery of care to patients most at risk of hospital admission, working with staff from different providers, including primary care, community care and social care.

- Good cross-sector financial flexibility in how organisations bear the costs of staff, estates and IT e.g. costs must be shared across patient pathways.
- Use of new technologies to make cross-site working and MDT working easier.
- New career paths. For instance development of nurse training rotations to include placements in general practice as well as acute, social care and mental health providers. This can be extended to include continuous professional development opportunities across healthcare boundaries.

**Enablers work plan**

<table>
<thead>
<tr>
<th>Time</th>
<th>Short term</th>
<th>Medium term</th>
<th>Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All enablers</strong></td>
<td>Implementation planning</td>
<td>Develop sustainability strategies, implementation management</td>
<td>Implement and monitor sustainability; Review, adapt and update strategies and systems</td>
</tr>
<tr>
<td><strong>Estates</strong></td>
<td>Completion of CCG Estates Strategies; delivery of immediate priorities; Strategy for WXH developed</td>
<td>Estate consolidation and rationalisation; develop hub models in each borough; business cases for significant investment (eg WXH)</td>
<td>Develop new infrastructure models, collocating health, social care and community facilities; major capital programmes underway</td>
</tr>
<tr>
<td><strong>Workforce OD</strong></td>
<td>Work with providers to develop implementation plans</td>
<td>Introduce new roles and MDT working</td>
<td>Ensure long term recruitment, retention and sustainability</td>
</tr>
<tr>
<td><strong>IT</strong></td>
<td>Fix the basics for infrastructure, deliver view only shared care records</td>
<td>Extend sharing of care records to Urgent care, GP OOH and 111</td>
<td>Deliver data sharing supporting structured data and bookable services</td>
</tr>
</tbody>
</table>
3. Our strategy (the response to the case for change)

Transforming Services Together (TST) aims to ensure that, over the next five years, all healthcare services in East London become high quality, safe and sustainable.

The whole health system needs to work together to make sure providers are able to consistently meet national and regional quality standards in a financially sustainable way. We will also need to have sufficient capacity to meet demand, working in a different way to meet population needs, for example through earlier intervention, prevention, self-management support and coaching skills for staff. Fundamental national standards are detailed in the NHS Constitution\(^ {28}\). These include the:

- 18 week target from referral to consultant-led treatment for non-urgent conditions
- two week target for being seen by a cancer specialist for urgent referrals where cancer is suspected
- maximum four-hour wait target in an emergency department from arrival to admission, transfer or discharge.

Clinical sustainability also means providers are able to progress towards meeting the London quality standards for acute emergency and maternity services\(^ {29}\) which include that:

- all emergency admissions are seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival to the hospital
- senior decision-making and leadership is available on acute medical/surgical units to cover extended day working, seven days a week
- access to key diagnostic services is available in a timely manner, 24 hours a day
- providers are able to meet requirements for emergency care medicine staffing, paediatric emergency staffing and obstetric and maternity staffing ratios.
- Greater provision of seven day services where it will improve patient care

The following chapter illustrates our response to the case for change. It details our continuing focus on prevention and health promotion and outlines our strategy for the three main areas of the Transforming Services Together programme – care closer to home, strong sustainable hospitals and working across organisations. This chapter also looks at how we are taking forward improvements to mental health care and children and young people’s care, which are embedded in all our work. Specific initiatives are identified and described in more detail both in chapter 4 of this document and in part 3).

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\(^{29}\) Acute Emergency and Maternity Services: London Quality Standards (2013)
3.1 Helping people manage their health better

Encouraging people to invest time in their own health and wellbeing and improving the support the NHS offers will improve people's health and contribute to a reduction in costs\textsuperscript{30}. Better Health for London\textsuperscript{31} and the NHS Five Year Forward View (FYFV) acknowledge that the future sustainability of the NHS hinges on a radical upgrade in prevention; unless we take prevention and public health seriously, this will adversely affect the future health and wellbeing of Londoners, particularly young Londoners, and the sustainability of the NHS, and tackle the 4\% annual increase in demand for health care.

The main changes we propose

**Support people to live healthier lives:** Health checks, social prescribing and the establishment of community activity groups all support people to live healthier lives. Social prescribing offers an innovative way for GPs to prescribe alternative community-based support that compliments traditional medicine. For instance people can be referred to local activity groups if it would better meet their health and wellbeing needs.

Organisations also need to help staff in encouraging people to tackle unhealthy behaviours. The *Case for Change* identified that staff often receive little formal training on behavioural change techniques. Building on the work Barts Health has been conducting with the Centre for Behaviour Change at University College London, work should take place with education providers to equip health professionals with the skills they need to support people to stay well and make every contact count.

Organisations also need to build on existing innovative practice in identifying and supporting people who may be damaging their health through harm ing behaviour such as excessive alcohol consumption. For example, Barts Health is working towards reviewing all patients who attend emergency departments with alcohol misuse symptoms, to make sure that they always obtain the advice and support they need. The main focus of our improvement is overseen by each of the borough's Health and Wellbeing Boards, which have many common improvement areas, and have a desire to strengthen collaboration to support prevention. The Healthy London Partnership\textsuperscript{32} supports London-wide initiatives on engagement, in particular on childhood obesity and improving workplace health.

**Make our schools and workplaces healthier:** Developing healthy environments in schools and workplaces is one of the most obvious opportunities to support people to live healthier lives. The London Health Commission stated that creating a healthier London requires ‘a new coalition that brings together local government, the health service, the voluntary sector, employers, schools and colleges, transport and the wider public and private sector’\textsuperscript{33}.

- In schools, this may involve encouraging greater participation in physical activity. Less than 50\% of children in Newham and Tower Hamlets participate in three hours of high quality physical education or extra-curricular sport a week\textsuperscript{34}.

\textsuperscript{30} Local Government Association. *Money well spent: Assessing the cost effectiveness and return on investment of public health interventions.* (2013). This report included a review of 200 NICE evaluated public health interventions finding that 15\% made a direct cost saving and 70\% were good value for money (<£20k/ QALY (Quality Adjusted Life Years)
\textsuperscript{31} www.londonhealthcommission.org.uk/better-health-for-london
\textsuperscript{32} www.myhealth.london.nhs.uk/healthy-london/prevention
In workplaces, health and social care organisations need to lead the way in offering healthy environments that encourage good health and wellbeing amongst staff. For example, social marketing campaigns in some NHS organisations have encouraged people to burn excess calories by taking stairs instead of lifts.

**Identify physical ill health earlier:** Existing screening programmes such as for cancer and health checks, help diagnose illness at an earlier stage, which increases the chances of successful treatments. Analysis of public health information and GP records indicate that up to a quarter of diabetics in East London remain undiagnosed, meaning there are tens of thousands of people who are not receiving the treatment and advice they need to stay well.

**The benefits of these changes**

The expected benefits of making these changes are:

- a healthier population, with improved quality of life
- people with long-term health problems will be better supported to manage their own illness and will be healthier
- a reduction in emergency attendances and admissions to hospital
- a more supportive patient experience of care
- stronger community infrastructure
- healthier staff.

**Fast food outlets near schools in Newham**


The diagram illustrates why creating a healthy environment is so important. The London Health Commission identified tackling the number of fast food outlets near schools as a key priority that local authorities could work on together. In close proximity to seven schools in Newham there are 29 fast food outlets.
3.2 Care closer to home

Context: Five Year Forward View

The Five Year Forward View (FYFV) sets out a clear vision and direction of travel for the NHS – showing why change is needed and what it will look like. The future will see far more care delivered locally.

Family doctors (GPs) with a registered list of patients will remain as the foundation of NHS care. Over the next five years the NHS will invest more in primary care, while stabilising core funding for general practice nationally over the next two years. CCGs will have the option of more control over the wider NHS budget, enabling a shift in investment from acute to primary and community services. The number of GPs in training needs to be increased as fast as possible, with new ways to encourage retention.

Across the NHS, urgent and emergency care services will be redesigned to integrate emergency departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.

Transformation will require new partnerships with local communities, local authorities and employers, with decisive steps being taken to break down the barriers of how care is provided between family doctors and hospitals, physical and mental health, health and social care.

New integrated provider systems and organisations will enable the NHS to take a more holistic view of patient care. The NHS is committed to providing meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied in support of diverse solutions and local leadership, as well as new options for the workforce and technology; and better use of estates.

It is envisaged that delivering on the transformational changes set out in the 5YFV could deliver significant health outcomes and reduced health inequalities, radically improve patients’ experience of interacting with the NHS and result in annual efficiencies.

In taking up the gauntlet of the 5YFV, and recognising the significant challenges involved in developing care closer to home in partnership with acute services, we are working on an ambitious and innovative ‘Care Closer to Home’ (CCH) strategy, building on the work led by local Health and Wellbeing Boards. This work is focused on creating the right culture, capability and capacity to enable transformation in the community to improve individual and community well-being, manage ill-health and achieve a balanced health and social care economy.

East London is already benefiting from involvement in two national programmes (pioneer and vanguard) established across the UK. This support from pioneer and vanguard contributes to the development of new approaches to service commissioning and delivery, for example, the development of payment reform through Monitor’s National Integrated Care Forum, as well as direct learning from visits to international exemplars.

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35 Previously known as ‘Out of Hospital’ services
Making health a shared value

We know that people are happiest and healthiest when they are active, valued members of their communities, supported by a network of family and friends. These people may still require health and social care services, but they generally use services less often, and more appropriately than other people, avoiding crisis situations and improving their quality of life.

Our ambition is to change the prevailing social culture of over reliance on medical/hospital services to one where people take greater responsibility for their health. This type of culture change takes years to achieve and requires whole system drive and investment. It is also important to recognise the determinants of health cannot all be fixed by health services. Building on the instigation of Better Care Fund (BCF) plans, we must strengthen the relationships between the health, social care and third sectors to achieve health and social care integration and maximise the resource and commitment in the community to create a culture of health where the mindset and expectations for good health include:

- people taking greater responsibility for their own health and actions that influence their health
- people staying well in their own homes and communities.

Organisational development that fosters collaboration

Payment reform and incentives

Commissioners intend to reimburse and incentivise providers in ways that reinforce integrated working, with organisations collaborating to deliver quality, value-for-money care for patients in a sustainable local health and social care economy, as summarised in the 2012 Waltham Forest and East London Integrated Care Case for Change.

The financial model between commissioners and providers

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36 Although outside the remit of this investment case, the ambition for the whole system would be for other sectors to be included to maximise impact in tackling social and environmental determinants of health: housing, education, safety, food, alcohol and smoking.
37 In this document referred to as East London
38 Purple box indicates proposed strategic option. Green box the proposed interim option
In line with the Integrated Care Case for Change, and as reflected in the commissioning intentions for 2016/17, East London commissioners are committed to piloting a capitated budget in ‘shadow form’ from April 2016. A simulation exercise between commissioners and local providers is currently taking place. Across East London, CCGs and local authorities are committed to developing a common methodology for calculating a capitated budget, including common approaches to gain and loss sharing and common approaches to outcome-based payments. This work involves Monitor as part of East London’s pioneer relationship.

Provider development

Across East London, there is a commitment to embedding integrated working in the delivery of care, regardless of setting or provider. Each borough is developing its capacity for its various providers to operate collaboratively in networks or partnership arrangements. The diagram illustrates this journey, recognising that the pace of change will vary.

Building on existing work, the CCGs, working with partners in the health and social care system, will take forward the work to achieve mature integrated provider networks by 2021 by drawing on local, national and international knowledge and experience.

Developing new models of care

[Diagram illustrating the journey from Individual Health and Social Care Organisations to Integrated Health and Social Care Systems/Organisations (MCP, ICO etc.) through GP Federations, London Borough, Third Sector, Community, Secondary Care, and Mental Health.]
Summary: Current provider development

| Newham                      | GP networks | Primary care provider network is in development. A decision to form a single federation to deliver some integrated care services as part of a local provider partnership is planned for 2016/17. |
|                            | Integrated provider network | Created in 2014; renamed Sep 2015 as the 'Newham Integrated Provider Partnership' |
|                            | Accountable care systems     | Developing an establishment plan |
|                            | New model of care            | Legal entity formation process underway |

| Tower Hamlets              | GP networks | Primary care networks in place since 2009. The GP Care Group (GPCG) is the borough level primary care network |
|                            | Integrated provider network | The provider forum is the Tower Hamlets Integrated Provider Partnership including Barts Health, ELFT, GPCG and London Borough of Tower Hamlets |
|                            | Accountable care systems     | Awarded integrator function to THIPP following a non-competitive procurement process in March 2014 |
|                            | New model of care            | THIPP is a national vanguard, awarded 2015, taking forward Multi-specialist Community Provider (MCP) model |

| Waltham Forest             | GP networks | Developed a single network of GP practices with 100% population coverage and services from three hubs |
|                            | Integrated provider network | Provider network in development with the aim of a functioning local provider partnership from April 2016. Plans include: delayed transfers of care; first response/rapid response integration; 75 years+ population cohort/integrated complex care; 0-5 years population cohort; care homes |
|                            | Accountable care systems     | Developed an establishment plan and working with providers on how these initiatives should move forward in an integrated way |
|                            | New model of care            | Further to establishment of the provider network, plans for an appropriate legal entity |

**Strengthening integration of health and social care services and systems**

Too many people go into hospital or stay in hospital longer than necessary. Co-ordinated support early on, focused on a person’s well-being as well as their health and social care needs, can reduce their dependency on services in the long run and ensure that admission to hospital only happens when it is really needed; existing duplication in the health and social care system otherwise ultimately reduces effectiveness and costs money, which the transformation work being undertaken is mitigating.
Workforce development / new ways of working

Integration and cross-organisational working will require changes to the workforce and ways of working. Staff will be enabled to work more flexibly across organisational boundaries and shared care records will be fully established across providers.

Existing and planned changes to support integrated working include:

<table>
<thead>
<tr>
<th>Change</th>
<th>Detail</th>
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</table>
| Care navigators / coordinators              | • New roles have been created to support the patients identified in the population most at risk of hospital admission – in the first instance those at Very High Risk (VHR) and High Risk (HR) – working to achieve access to the most appropriate care and support for these patients, at a time and place that suits them.  
  • New staff have received bespoke training so that they can best support patients to navigate the system.  
  • Care navigators provide practical support for patients, (booking appointments and arranging transport), as well as work with the other professionals involved in patients’ care to support coordinated multi-disciplinary team working. |
| Case Management                             | • VHR risk patients receive dedicated, intensive clinical case management to plan and coordinate their health and social care. |
| Specialist input into the community         | • Care navigators/coordinators and case managers are underpinned by a MDT that is supported by specialist input e.g. community geriatricians, occupational therapists, physiotherapists and social workers.  
  • The MDTs meet regularly to act as ‘team around the patient’, and to ensure their approach is aligned and coordinated. |
| Generic workers                             | • For example therapy/rehabilitation assistants, working with other health care team members/specialists to improve a patient’s physical and mental health and their quality of life. |
| Physician Associates                        | • Working in community and primary care (please see chapter 4 of this document and part 3, section 11). |
| Support for development of MDT/ collaborative working | • Structure and process required to deliver MDT approach  
  • Organisational development to facilitate culture change  
  • Admin support and co-ordination for MDT approach |
| Care planning                               | • Standard template and process for care planning that is accessible by multi providers to enable coordinated care |
| Informatics                                 | • Access to the full patient record (shared care records)  
  • Access to systems  
  • Predictive algorithms and alerts  
  • Digital road map |
OD commissioner requirements over the next five years (unless otherwise indicated (specific requirements are shown in each section of Part 3)

<table>
<thead>
<tr>
<th>Key change area</th>
<th>Description</th>
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<tbody>
<tr>
<td>Embed the CCH strategy</td>
<td>Workshops and events with stakeholders, to embed the vision, values and deliverables</td>
</tr>
<tr>
<td>Develop the commissioning and provider landscape to</td>
<td>‘New models of care’ workshops to inform development of integrated provider systems/organisations including GP networks, and models of integrated commissioning</td>
</tr>
<tr>
<td>deliver the strategy</td>
<td></td>
</tr>
<tr>
<td>Develop MDT/collaborative working</td>
<td>Programme to strengthen MDT working (for staff with shared responsibility for care)</td>
</tr>
<tr>
<td>Support the introduction of new roles</td>
<td>Programmes to support nurses, HCAs, pharmacists, optometrists, practice managers, care navigators etc.</td>
</tr>
<tr>
<td>Develop leadership capability</td>
<td>Programme to support future CCH clinical / leaders</td>
</tr>
<tr>
<td>Development and empowerment of the community</td>
<td>Involve patient participation groups (PPGs), third sector and Healthwatch in co-design and delivery of the transformation programme and in building capacity in the third sector</td>
</tr>
</tbody>
</table>

Outcomes

The CCH strategy is focused on improving individual and community well-being, managing ill-health and reducing health and social care costs.

A summary of the anticipated activity shifts and financial benefits is set out below. The measurements for determining the success of the strategy in achieving targeted improvements to patient experience and health outcomes are described in individual sections in this document and Part 3.

Activity shifts

The aim is to reduce the number of acute attendances and admissions by improving earlier intervention and better care coordination, including self-care and prevention initiatives. Activity that is shifted from the acute setting needs to be re-provided via CCH initiatives or new models of provision in primary and community health services. The development of capacity in the third sector and the realisation of a culture of self-care will enable shifts of unnecessary activity from primary and community care.
TST modelling suggests that if we do nothing, about 1.1 million extra primary care attendances would be needed to meet new demand by 2026. With the impact of TST initiatives this figure reduces to c.600,000 extra attendances needed over the same period\textsuperscript{39}.

This reduction incorporates integrated care initiatives where, supported by new care models, patient care is provided in a more appropriate way. For example:

- A proportion of primary care activity seen in general practice can be shifted to pharmacy care and self-care, enabling general practice to have more capacity to support the delivery of more complex care.
- Approximately 140,000 outpatient appointments would be needed to meet extra demand by 2020/21. With the impact of TST initiatives, we may be able to reduce this by 20\%, including 5\% accommodated by primary and community care.
- Without TST, there is likely to be a rise in the numbers of people coming to Barts Health emergency departments of around 80,000 attendances by 2020. With TST initiatives, this is reduced so that attendances are maintained at today’s levels. This can be achieved through a combination of shifting activity; improving pathways and system efficiencies; and providing care in more appropriate settings. ‘Right sizing’ the acute bed base in line with TST strategic projections will be realised from increased capacity commissioned in primary care/ community, through the accountable care system, driving down the demand on the acute bed base.

**Our priorities**

Section 4 of this document describes the specific initiatives that require a particular collaborative focus to ensure delivery and have a material impact on the health and social care economy. These are:

1. Primary care
2. Urgent care\textsuperscript{40}
3. Integrated care

The full details of these initiatives are detailed in Section 4 of this document and Part 3, Sections 1 to 4.

\textsuperscript{39} TST Modelled Initiatives Summary Pack, November 2015
\textsuperscript{40} NB: does not include urgent care delivered under acute contracts in hospitals
3.3 Strong sustainable hospitals

Even though our focus is to help people stay fit and healthy and to provide care closer to home, we need to make sure that when people do fall seriously ill or need emergency care, there are safe and sustainable services in local hospitals.

The hospitals in East London work together to provide care for the local population. The quality of care in these hospitals is variable, some services are world class and others are poor. To improve this, there needs to be a continuous focus on quality and safety. Some changes are small and will cost nothing to implement, others require organisations, staff and the public to work together to deliver improvements. This chapter outlines how hospitals will change over time, and focuses on the changes we need to make to Newham Hospital, The Royal London Hospital and Whipps Cross Hospital in the next five years to ensure that they are able to provide high quality, safe and sustainable services.

We will not be able to effectively deliver care for our population if we do not change the way hospitals work

Our population is growing rapidly. If we do not change the way we work, we will need to build 550 beds (the equivalent of another hospital) to cope with the growth over the next ten years. This is not the right thing to do for patients, as people already spend far too long in hospital. Older people in particular become institutionalised and find it difficult to regain their independence in the community after a spell in hospital. Nor do we have the funds to build, staff and maintain this many beds.

If we don’t change, clinical quality will fall, financial problems will become worse and some hospitals may have to stop providing certain types of care. This is unacceptable. We must change the way services work to meet the needs of patients, while using our resources in a sustainable way for the future.

Our strategy

We need all of our hospitals to function effectively to serve our growing population but they will have to look and work differently in the future. Each of the existing emergency departments and maternity units will need to be retained to deliver high quality local care. However our changes, in line with national policy, will mean that the way the sites work and the role they play will change in the following ways:

Improved local care with specialisation where this improves outcomes and delivers safer care

In order to effectively provide care for the growing populations we need to make sure that Newham and Whipps Cross are able to deliver high quality care locally and function as strong local hospitals.

We also need the Royal London to function effectively as both a local hospital and a tertiary centre, this doesn’t really happen at the moment. The Royal London Hospital site is often too busy treating emergency and acutely ill patients to function effectively as a tertiary centre or treat patients needing planned surgery in a timely manner. This results in large numbers of planned surgery cancellations and patients staying in hospital longer than they should, affecting not only patients locally but those being transferred from further away.
Ensuring sufficient local capacity and capability at the Newham and Whipps Cross sites to treat more patients will release some of the pressure on the Royal London and improve both the delivery of tertiary and local services.

Alongside improved local delivery, there are also opportunities for Barts Health as the largest hospital trust in Europe, to better manage its services across sites by taking advantage of opportunities to deliver services at scale. In some cases we need to bring together services and treat larger numbers of patients in one place. This is in line with the *NHS Five Year Forward View* that outlines that smaller acute hospitals need to work together in collaboration to take advantage of the benefits of scale.

**More integration with the community and social care**

Our hospitals need to be better integrated with the community and form stronger partnerships with the charitable and voluntary sector. We need to make sure that local services run as effectively as possible alongside other clinical teams both on and off the hospital sites to deliver the highest quality of care in the future.

This will mean changing the way that hospitals work, with local GPs and community teams as well as non-clinical providers. In some cases, this will mean working closely with other provider organisations to deliver care outside of hospital. This might be as part of new integrated models including primary and secondary providers, as set out in the *NHS Five Year Forward View* - as is happening in Tower Hamlets as part of the vanguard work.

**Better network working across our sites and more widely**

In line with both national guidance, we need to be far better at organising and simplifying the urgent and emergency care system and network arrangements. Our proposals will achieve both of these, standardising and improving both the system and the standards of care.

Currently, the three main acute sites do not consistently meet London quality standards indicating that sometimes we are not delivering the quality of care that we should. For example, we know that no site other than the Royal London Hospital can offer access to emergency interventional radiology in under an hour. Our approach outlines where we need to look across sites and in some cases change configurations to improve network arrangements for life- or limb-saving specialist services.

**Changes need to build on, and reinforce, local sustainability plans and improvements**

These changes will need to be made alongside the local work that all our hospitals need to make to continue to deliver safe services and improve care. We know that Barts Health has improvement plans to deliver safe and compassionate care as the result of the recent CQC reports. This strategy aims to support, reinforce and build on this work.

We also know that both Barts Health and CCGs are facing financial challenges – the changes outlined in this section directly contribute to both the individual organisations and the wider system, improving the financial positon. This is detailed in the section on financial impact (Section 5).

**Our approach**

Section 4 of this document (and Part 3, Sections 5 to 7 for more detail) describe the specific changes that need to be made in the next five years to ensure that Barts Health sites can
both serve the local population with high quality care and continue to operate as a tertiary centre providing world class care to the whole of the south of England. These initiatives are:

- Establish surgical hubs
- Establish acute care hubs
- Maternity – increase the proportion of natural births

Without these changes, or making them in isolation, risks the overall sustainability of both Barts Health and the wider health and social care system. In the next stage of planning, the interdependencies between the changes need to be fully understood to ensure benefits are delivered, and that services remain safe and function correctly during implementation.

### 3.4 Working across organisations

Many of the initiatives we are taking forward will require organisations to work together more closely than ever before. For example, clinicians from across primary, community and secondary care organisations need to work together to agree pathways that speed up the patient journey.

In addition, organisations across east London have agreed to work together to increase the number of physician associates working in primary and secondary care organisations, as well as defining a joint-strategy for the future of Mile End Hospital and Whipps Cross Hospital.

The following six system-wide initiatives need collaborative working to transform care and deliver whole system improvement:

1. Transform the patient pathway and outpatients
2. Reduce unnecessary testing
3. Deliver shared care records across organisations
4. Explore the opportunity that physician associates may bring
5. Develop a strategy for the future of Mile End Hospital
6. Define a strategy for the future of Whipps Cross Hospital

The full details of these initiatives are detailed in Section 4 of this document and Part 3, Sections 8 to 13.
3.5 Cross cutting themes

Two themes in particular are found threaded through all the proposed initiatives: mental health and services for children and young people.

Mental health: taking forward transformation

Mental health affects us all and has a large impact on society. One in six of the population suffers with a mental health problem at any one time, with one in four suffering at some point in their lifetime. Of all lifetime mental disorders, 75% will manifest by the age of 18.

Mental healthcare provision in East London is relatively good – both NHS mental health providers, East London NHS Foundation Trust (ELFT) and North East London NHS Foundation Trust are financially stable, provide good quality care and rank highly in terms of staff satisfaction. However, although mental ill health accounts for 23% of the health burden, it receives only 13% of national NHS spend.

The government focus on mental health has increased in recent years, with milestones such as the publishing of No Health Without Mental Health, initiatives such as the Crisis Care Concordat, and the setting up of the Mental Health Taskforce in 2015. The Five Year Forward View also emphasises the need to improve prevention strategies and bring physical and mental health care together. Additionally, the government has invested in certain areas of mental healthcare, implementing waiting time targets and minimum expectations for services such as Improving Access to Psychological Therapies (IAPT), Child and Adolescent Mental Health services (CAMHS), and early intervention in psychosis. The political landscape is thus primed for mental health services to reach the goal of ‘parity of esteem’ with those of physical health.

The Case for Change identified a number of mental health-related challenges, predominantly pertaining to Barts Health. For example, it was shown that people with co-morbid dementia spend an average of 10 extra days in hospital when compared to those without. Also, the high incidence of mental health problems in emergency department presentations, and the additional healthcare costs for those with long-term conditions and co-morbid mental health difficulties were also highlighted.

Summary of progress so far

During 2015 we have held several engagement events with clinicians, managers, commissioners and service users. CCGs, local authorities, providers and third sector organisations have had input into the priority areas. These local stakeholders suggested that the TST mental health workstream should build on the challenges posed in the Case for Change, and agreed four service areas for investigation: perinatal (the period from conception up to one year after the birth of a child), CAMHS, crisis care and dementia.

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The mental health workstream has been building engagement and enthusiasm for change, understanding what services are currently provided, agreeing a high level interim strategy with clinicians and commissioners and more detailed visions and principles for three of the four service areas. Additionally, the CCG commissioners have all developed CAMHS transformation plans, part of an NHS England development to release additional funding to improve the mental health of young people.

The interim strategy highlighted the need to improve services in four key areas, and several key principles for designing new services (shown below). Improvements in mental healthcare will span the whole range of care services, from primary care and secondary care, to social care and universal services. The strategy and supporting initiatives will consider impacts on these different sectors, addressing the capacity and capability to improve mental health care. This may require upskilling the existing primary care and physical care services, and developing additional capacity to address need earlier and reduce the demand for secondary community and inpatient mental health services. An example where this has already occurred is the development of enhanced primary care mental health services.
Key areas of work

1. **Perinatal mental health vision**

“All expectant and new mothers and their partners will have the knowledge and skills to feel confident in looking after their own and their baby’s emotional wellbeing; should they need additional support, it will be identified early, easy to access, quick, and integrated with their other perinatal care.”

- Mental health is everyone’s business – everyone involved in the care of women in the perinatal period will have an active part to play in their mental wellbeing.
- Perinatal mental health services will work with universal and antenatal services, good communication, a unified referral process, and information, advice and skill sharing.
- Access to services will be easy, with rapid access to psychological therapies where required.
- All those involved in perinatal care will have sufficient skills to embed mental health care into existing care.
- Mental health and wellbeing support will be available to all mothers, partners and babies, including a range of third sector and community services.

Achieving this vision will require the integration of mental health into all parts of the maternity pathway, from pre-conception through to the end of the first 1,001 days of a child’s life[^46]. This will be achieved through implementation of the perinatal mental health pathway under development by the London Perinatal Strategic Clinical Network (Oct 2015)[^47].

2. **Child and Adolescent Mental Health Services (CAMHS)**

All CCGs in the TST programme have developed transformation plans in line with *Future in Mind[^48]*, as part of NHS England’s programme to improve mental health services for children and young people. These set out how CCGs will invest additional funding from the government over the next five years to make a measurable difference to children and young people. All of the plans set out how the CCGs will achieve the following principles:

- Destigmatising mental health.
- Focus on *resilience* and *prevention*, working with children and parents.
- As a health and social care system we can identify and act on mental health issues earlier.
- Integration and streamlining of services that are consistently equitable and easy to access and navigate, removing barriers between services and focusing on the person.
- Delivering the outcomes that matter to children and young people, including hard-to-reach groups, and ensuring that transitions to adult services are needs-based and well-managed.
- Taking a whole systems approach, working in partnership across primary and secondary care, community and acute providers, education, social care, voluntary sector and the police. Commissioning together and commissioning on outcomes.

[^46]: Durkan, M. et al. (2013), *The 1001 Critical Days: The Importance of the Conception to Age Two Period.*


• Reduce the number of self-harm presentations for children and young people.

The local transformation plans will be published following a sign-off process by NHS England. In line with the development of an East London mental health strategy, we will analyse these plans and synthesise them to provide a regional CAMHS strategy, paving the way for increased collaboration on cross-borough challenges such as health promotion and illness prevention, whilst supporting individual CCGs to implement local initiatives.

3. Crisis care

Each CCG, in collaboration with local partners such as local authorities, police, and third sector organisations, has developed a local concordat vision and plan. Achieving improvements in crisis care will involve implementing those plans locally and regionally, integrating delivery with other urgent and emergency care services such as ambulatory care, NHS111, out of hours GPs and emergency departments. These plans are guided by the principles of the Crisis Care Concordat, which are listed below:

• Access to support before crisis point – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.

• Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.

• Quality of treatment and care when in crisis – making sure that people are treated with dignity and respect, in a therapeutic environment.

• Recovery and staying well – preventing future crises by making sure people are referred to appropriate services.

4. Dementia vision

“All those with dementia will receive the support they require to live as independently as possible; they will have been assessed and diagnosed early, and integrated support for them, their families and carers arranged quickly.”

• Dementia is everyone’s business – everyone involved in the life of people living with dementia has an active part to play in their wellbeing.

• Dementia services will work alongside health and social care services, with good communication, availability of information and advice and skill sharing.

• Physical and mental care of dementia sufferers will be joined up in order to reduce the number of presentations to emergency departments and lengths of stay for admissions.

• Carers will have access to information, advice, education and support.

• We will support the development of dementia-friendly communities.

• We will ensure those with dementia have dignity at the end of their life.

CCGs have made large strides in improving dementia diagnosis rates over the last year and their integrated care programmes are expanding to provide coordinated care for those at moderate and high risk of admission to hospital. Whilst these elements are improving care
for those with dementia, achieving the vision will require greater focus on all parts of the system, within and outside health.

**Next steps – system sustainability**

The focus to date on the four areas described above only represents a portion of the mental health system (mainly in secondary care mental health services). This focus was derived from, and intended to address, the *Case for Change*. However, the areas do not address the issue of system sustainability for the mental health sector as a whole. The mental health system is under pressure, but it is still relatively resilient. This may change over the coming years as demand increases, and we want to pre-empt where the weaknesses in the system are, beyond that achieved by the *Case for Change*.

A review of the whole system would provide a foundation for producing a system-wide mental health strategy; this has been a recent focus at a national level in NHS England. We will refresh and build on work done several years ago. This would enable the development of a regional, cross-CCG needs analysis; project prevalence and population growth; and identify potential gaps in service provision and pressure points. It would also answer the following and other questions for the whole system, not just the four areas described above:

- How many extra beds will be required in 5-10 years? How could we reduce the need to commission these through community provision instead?
- What are the current activity levels for all services in terms of referrals and cluster episodes? How does this compare locally and nationally? How might this change in five to ten years?
- What are current waiting times for treatment? How might these change as demand increases or as they system changes?

**Children’s and young people’s care: taking forward transformation**

Children and young people aged 0-19, represent 27% of the population in Newham, Tower Hamlets, Redbridge and Waltham Forest – higher than the national average. The Office for National Statistics projects an 8% increase in the group over the next five years (representing an additional 16,000 children and young people)\(^49\).

High levels of deprivation, high levels of child poverty, poor nutrition\(^50\) and high rates of obesity are also expected to contribute to the demand of health services.

However, child and adolescent health services in our area have some excellent assets. For example, the children’s specialist hospital at the Royal London Hospital, which includes a paediatric intensive care unit, and the Newham University Hospital Paediatric Clinical Decision Unit which operates in the emergency department and provides important observation facilities, reducing hospital admissions.

But there are challenges to the system, raised by clinicians and young people including:

- a lack of coordination and joint-working
- numerous hand-offs between services, resulting in duplication

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\(^50\) Public Health England (March 2014), *Child Health Profiles*
• high numbers of referrals to general paediatrics, orthopaedics and dermatology, and emergency department attendances for conditions better managed in primary care, resulting in large waits and unnecessary use of services

• children and young people and their parents/carers not being empowered to support themselves and access age-appropriate services at a location and time that suits them.

In September 2014, the *Children and Families Act* was enacted, setting out the need for health, social care and education services to work more closely together to provide care that is centred around children and their families. Other recent publications such as the *Five Year Forward View* and *Future in Mind* have supported this drive.

**Summary of strategy**

Our strategy aims to place children and young people at the centre of care and services across health, social care and education. Effective services from early years into adulthood will support this generation and begin to establish healthy lifestyles and self-care as the norm for future generations.

The children and young people’s services clinical working group identified four principle concerns: transitions of care, integration of community care, hospital care pathways and urgent care. Central to these are the overarching principles of public health, prevention and safeguarding that are a consistent feature of good care for children and young people; these are summarised in the diagram below.

Transformational changes for children and young people’s services are included across the programme and in many of the individual initiatives (see section 4 of this document and Part 3).

Realising the benefits in terms of improved care for children and young people will require collaboration across organisations. The East London CCGs will be able to use the TST governance structure (see Section 6) to track delivery and progress.

The model of care that we would like to establish over the coming five years is set out in the themes below. This includes information on the changes we will make, the benefits we hope to see and how we intend to take this work forward. We have also described examples of excellent practice which are already beginning to show our vision in action.

**Integrated care (working across health systems and with the local authority)**

Commissioners and local authorities in each borough will develop local integrated care plans and identify opportunities for joint commissioning. They have developed a joint statement, setting out a commitment to work together to:

- develop local integrated care services
- jointly commissioning 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.

This will implement the requirements of the Children and Families Act.

**Multidisciplinary teams for children with complex needs**

Local models of coordinated care have been developed in line with a common set of principles. These models, to be implemented locally by CCGs, will introduce detailed, structured care plans, developed by multidisciplinary teams (MDTs) of health, social care and educational professionals, and available electronically between organisations. A virtual ward is where MDTs are brought together by secure technology to enable health professionals to discuss and coordinate the care and treatment for patients in a community setting. Care will be proactively managed by a care coordinator. Parents, carers and patients will be fully involved in the development of care plans, including regular check-ins prior to virtual ward MDT meetings to assess progress.

**Redesigning pathways for long term conditions**

As part of the patient pathway and outpatients initiative, evidence-based clinical pathways for conditions that are a priority for our young population will be co-designed. Priority conditions include epilepsy, asthma and diabetes. Children, young people and their families will be central in the design process to ensure pathways are appropriate to their needs and better support them to manage their own conditions. There will be a particular focus on community delivery and transitions to adult pathways.

**General paediatric outpatient referrals**

There is a need to improve access for primary care to fast specialist advice by phone and email; and investigate use of locality paediatricians. Referral criteria and rules for conditions with a high volume of referrals such as asthma and eczema will be reviewed and guidelines will be standardised collectively by community, primary and secondary
care clinicians. Access to diagnostics from primary care will also be reviewed to further identify opportunities to provide care in the community. This process will be led by the WEL(C) Paediatric Commissioning Alliance in partnership with the Barts Health Children’s Health Network Board. Impact assessments have been included in the ‘transform the patient pathway and outpatients’ (see appendices).

**Paediatric urgent care, paediatric emergency care, and paediatric surgery**

The systems in place to deliver safe, high quality services for urgent and emergency services will need to change. The new model will involve earlier access to expertise and diagnostics, the development of acute care hubs and better use of ambulatory care. Impact assessments have been included within the acute care hub transformational scheme and urgent care scheme. These changes are detailed in appendices 2, 6 and 9.

Surgery pathways for children and young people also need to be improved in order to reduce waiting times and improve quality and patient experience whilst managing increasing demand. Developing surgery hubs will enable delivery of the appropriate expertise to deliver safe services.

In order to ensure consistency of pathways in urgent care, emergency care and surgery, the models are being developed through the TST programme for all ages, including children and young people; progress is described elsewhere in this document.

**Mental health**

*Future in Mind* (2015) set out the need to improve the mental health of children and young people in our population. The TST proposals for improving CAMHS are described in section 5.3 on mental health.

**Expected outcomes**

- CYP will be more engaged in treatment
- Consistent, joined-up services with a better patient experience of care
- Improved transition to adult services
- Reducing referrals to 2° care and presentations to A&E
- Reduced waiting times
- Reduced bed use
- Care closer to the community - more self-care and management in 1° care

CYP
Work in progress

- Virtual Wards: Tower Hamlets has extended its virtual ward programme, called the Bridge Pilot, to 2015/16 and has expanded the cohort to 50 patients. This programme is for children and young people with intensive care needs, where care will be proactively managed by a care co-ordinator, between health, social care and education, with input from parents and or carers. Waltham Forest is in the process of recruiting for the coordinated care model. Newham is considering the opportunity for a virtual ward as part of the Children’s Academy integrated care model.

- Personal health budgets: Across East London the CCGs and local authorities are working in partnership on the development of personal health budgets (PHBs)

- Paediatric emergency care: Development of Paediatric Assessment Unit at Whipps Cross is underway, an initiative aligned with the acute care hubs programme (see Part 3, Section 6)

- Youth commissioners: Delivery of summer workshops focusing on local diabetes services and areas of the care pathway with opportunity for improvement, in particular transition services.

- Joint commissioning boards and integrated child health transformation boards have been set up, signing off on initiatives such as personal health budgets

- Commissioning Intentions included outpatient redesign (including enabling quicker access to specialist advice, both virtually and face-to-face).

Next steps

Many of the plans are being developed and implemented locally by CCGs and their local authority counterparts. Some of the initiatives are being developed alongside the equivalent adult initiatives (for example, urgent care, acute care hubs and surgery – please see appendices).

The Waltham Forest, East London and the City (WELC) Paediatric Commissioning Alliance will continue to work closely with local authority partners to further support the delivery of holistic and coordinated care. The alliance will also be sending representatives to the Barts Health Children’s Health Network Board to ensure progress and planned changes are worked through in coordination with the provider.

Newham CCG, through the diabetes youth project has been engaging with young people in Newham living with diabetes in order to understand their wishes in order to redesign pathways and services. The initiatives proposed at the summer workshops on youth diabetes have been evaluated and prioritised by the youth commissioners. The group has drafted a phased approach, with the first set of changes scheduled to be implemented from April 2016 (with the project informing commissioning intentions in December 2015, and drafting any business cases as appropriate).

As part of sharing good practice across the CCGs, the intention is for the youth diabetes programme to be evaluated and extended to Waltham Forest and Tower Hamlets.
4. The changes we have prioritised and their impact

Identifying the key initiatives

The TST programme has identified over 100 potential improvement schemes. As part of the programme stocktake in August 2015 a set of transformation criteria were agreed by the programme board in order to focus and prioritise the work of the TST programme. Each of the longlist schemes were assessed on whether they:

- required whole systems collaboration and financial leverage to ensure delivery
- had a material capital requirement which needs external sourcing or sign off
- result in a material activity shift in one or more organisations
- result in a fundamentally new and innovative service model which has the capability to be of interest to other organisations either locally in East London or nationally.

This resulted in a shortlist of 13 priority initiatives which are the areas of focus in this section and (in greater detail) Part 3 of the document.

Other schemes that did not meet the criteria were captured, accounted for, and are being progressed through local delivery and ‘business as usual’. The diagram below outlines the process and timelines.

The 13 prioritised initiatives were grouped into three clusters supported by a range of enablers.

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care closer to home transformation</td>
<td>Focuses on the shift in emphasis to care closer to home and in the community.</td>
</tr>
<tr>
<td>2. Strong sustainable hospitals</td>
<td>Focuses on change in hospitals.</td>
</tr>
<tr>
<td>3. Working across organisations to continually improve care</td>
<td>The transformation that requires whole system working.</td>
</tr>
</tbody>
</table>
The 13 initiatives that satisfied one or more of the transformational criteria (and the criteria they met)

| Care Closer to Home | • Improving access, capacity and coordination in primary care  
|                     | • Expand integrated care to those at medium risk of hospital admission  
|                     | • Put in place a more integrated urgent care model  
|                     | • Improve end of life care  
| Working across organisations to continually improve care | • Reduce unnecessary testing  
|                     | • Transform the patient pathway and outpatients  
|                     | • Develop a strategy for the future of Mile End Hospital  
|                     | • Define a strategy for the future of Whipps Cross  
|                     | • Deliver shared care records across organisations  
|                     | • Explore the opportunity that physician associates may bring  
| Strong, Sustainable Hospitals | • Establish planned care surgical hubs, including IR  
|                     | • Establish acute care hubs at each site  
|                     | • Maternity – increase the proportion of natural births  
| These changes will be supported by | • Workforce and organisational development  
|                     | • Informatics  
|                     | • Estates  
|                     | • Communications and engagement

The 13 initiatives also help achieve the programme strategic outcomes
Transforming Services Together requires whole system working and collaboration to deliver the benefits. Our programme structure and governance is now aligned with these prioritised initiatives (see 6.1).

4.1 Expand integrated care to those at medium risk of hospital admission

During the last two years, our health and social care services have been working together more closely to ensure those people at the highest risk of admission to hospital experience coordinated case management. This is because our Case for Change showed that around 20% of patients account for 80% of healthcare costs and that people’s experience of care is not always as joined up as it could be.

Over the next five to ten years, our integrated care approach will be further developed to ensure that interventions are available for a fully risk stratified east London population. For example:

- Case management will be in place for the very high risk and high risk of hospital admission cohorts of patients.
- Care coordination and navigation will be in place for the medium risk cohort.
- Self-care and self-management approaches will be available for people with low risk and very low risk of admission to hospital.

This care model will ensure that care plans are developed around the needs of those people most at risk of admission to hospital, discharge planning is coordinated between health and social care services and people are given the support they need to stay well through prevention and self-care management interventions. Important enablers of this work are the development of shared care records, a workforce that is increasingly able to work across care settings, as well as the organisational development work that will support providers and staff to work together.

Full details of the clinical model, investments and impact can be found in Part 3, Section 1.

4.2 Put in place a more integrated urgent care model

Rising demand due to population growth, combined with the planned reconfiguration of the emergency department at King George Hospital means that without change there is likely to be an increase of 92,000 people visiting our local emergency departments. We know that up to 21% of those who currently attend emergency departments, but who are not admitted, require no significant treatment and could have received their treatment in another setting. Our Case for Change also highlighted that people find the urgent care system confusing and hard to navigate.

Our strategy is to simplify the entry into the urgent care system so that people receive the right care, in the right place, first time. We will develop an online directory of services so people can ‘click first’, which will be simple and easy to use to describe where services are and how to access them. The NHS 111 clinical triage service will be integrated with the

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52 Integrated Care Case for Change - Summary, WELC 2012
53 SUS data 2014/15
urgent care system allowing the service to direct people to pharmacies, or book appointments for people directly. We also know that unless people are supported to manage minor illnesses themselves better, the system will not be able to cope with increasing demand. Online resources and applications will be developed that offer advice and the number of people encouraged to use pharmacy services will be increased.

Finally, the urgent care hubs at Newham, Whipps Cross and The Royal London will be strengthened and will need to work more closely with hospital services to ensure emergency departments are for emergencies only. This will include the strengthening of the workforce skill-mix and improved access to rapid testing facilities, for example X-ray and bloodtesting, when they are required.

Full details of the clinical model, investments and impact can be found in Part 3, Section 2.

4.3 Improve end of life care

As a result of the changes we propose, more people will be able to die in accordance with their wishes. Organisations will work together to improve end of life care, focusing on better understanding people’s preferences towards the end of their lives, conducting effective care planning and making sure these care plans are shared between providers. In the future, people will be able to access high quality and responsive care in the community round-the-clock, resulting in fewer people needing to be admitted to hospital during the final months and weeks of their lives. We will also provide better training to staff to help them better support people who are dying. This will include training to support staff to start conversations early regarding care preferences.

Full details of the clinical model, investments and impact can be found in Part 3, Section 3.

4.4 Improving access, capacity and coordination in primary care

Without change, by 2020 population growth would necessitate over half a million primary care appointments per year. But because of the age profile of our workforce and national recruitment challenges, we expect there to be 136 fewer GPs working in east London by 2020. This means we need to fundamentally change the model of primary care and diversify the workforce. Whilst we expect the overall number of GPs to reduce, by 2020 we expect there to be 58 more pharmacists, 25 more physician associates, 49 more nurses and 46 more community health service staff working in primary care.

The changes aim to transform, modernise and redesign primary care by focusing on improving access, establishing proactive care models and coordinating care better. For example, access can be improved by allowing people to receive healthcare advice by phone, Skype or email and our workforce challenges will be overcome (for instance) by pharmacists working in primary care, allowing GPs to concentrate on more complex work.

People will be supported to stay healthy and well through better self-care support whilst symptom checkers and online triage systems will also be introduced. In future, to cope with rising demand, up to 24% of current general practice appointments will need to be delivered through services like pharmacies or through supporting patients to manage their own health.
We recognise that primary care has a crucial role to play in providing care coordination and care planning for people with long term conditions. This will require some appointments to be longer, for example for care planning sessions.

In order to transform, primary care will need to be commissioned at greater scale to cope with our future challenges. Given our workforce, capacity and estates challenges, we believe this can only be delivered in primary care centres with patient list sizes over 10,000, or through smaller practices working together at scale in integrated provider networks, or through collocated facilities at hubs.

Full details of the clinical model, investments and impact can be found in Part 3, Section 4.

### 4.5 Establish surgical hubs

We want to establish a network of surgical hubs, one at each Barts Health hospital site (Newham, Royal London, Whipps Cross and St Bartholomew’s). These would operate in networks, to provide safer, less variable care delivered by the right person, at the right time.

Surgical hubs allow services to be delivered locally wherever possible and bring services together where this improves outcomes and delivers safer care.

This new model would mean patients only travel when absolutely necessary and would have preoperative appointments and tests at their local hospital.

Each site will have a ‘core’ surgical offering high quality local care that also backs up maternity and emergency services. This will be combined with a ‘core-plus’ set of services where there are advantages in delivering surgery at scale in terms of quality or safety.

As part of this model, each site would host core services and a different combination of core plus and specialised hub functions. For example, Whipps Cross Hospital could become a specialised hub for urology surgery, whilst Newham Hospital may become the specialist hub for arthroplasty (hip and knee) surgery.

*Proposed segmentation of surgical services*
Through each site providing a combination of core and core plus surgical services, all sites would maintain the surgical capacity and capability to support emergency and maternity services, safely – see below for details of a potential configuration of services with the sites and specialties. This will need to be further tested and enhanced including through appropriate engagement with the public, staff and local stakeholder groups.

Potential configuration of surgical services across sites

Over the next six months we will be working to test and enhanced this, as well as other options including through appropriate engagement with the public, staff and local stakeholder groups.

There would be a dedicated emergency surgical service provided around the clock through a network across our hospitals. This would ultimately improve clinical outcomes and improve patients’ quality of life after life- or limb-saving surgery.

This change would also allow:

- better networking with other NHS trusts across London through clearer access to strengthened specialist hubs and a world class tertiary centre
- surgical services would be safe and sustainable in line with the Royal College of Surgeons guidance and policy on minimum volumes\(^54\) allowing surgeons to maintain their skills by treating larger numbers of patients
- dedicated recovery nursing teams and equipment to enhance recovery and reduce the amount of time patients spend in hospital, getting them home quickly and safely.

The full details of the clinical model, investments and impact are in Part 3, Section 5.

\(^{54}\) Royal College of Surgeons [www.rcseng.ac.uk/healthcare-bodies/clinical-policy/standards-and-policy]
4.6 Establish acute care hubs at each site

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. Therefore, we want to strengthen emergency departments by establishing acute care hubs at each site where ambulatory\textsuperscript{55} care is the default option for treatment.

This model, in line with the findings of the Future Hospital Commission, aims to put patients’ needs first and redesign hospital services to meet them\textsuperscript{56}. 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 should be admitted to a specialist ward.

This would mean establishing ambulatory care on all three sites and 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.

This would also reduce the demand for hospital beds, allowing the system to serve the growing population without building more capacity.

Full details of the clinical model, investments and impact can be found in Part 3, Section 6.

4.7 Maternity – increase the proportion of natural births

At its core, the new maternity care model focuses on ensuring that service provision is orientated around providing a good experience of care for women, supporting them through their pregnancy, birth and post-birth journey.

Described by clinicians as the ‘default’ place of birth, 86% of women across Barts Health gave birth in hospital-based, obstetric-led settings in 2013/4, although within this figure there is significant variation across the three sites. This is not safe nor sustainable for the future.

The new continuity of care model aims to encourage more women to choose birth settings appropriate to their risk level. This will mean greater numbers of women will be supported to give birth outside the obstetric unit. As more women are supported to have a natural birth experience across a variety of settings, less medical interventions such as Caesarean section will be required and we will not need to build additional obstetric capacity in the next five years. As part of our ongoing work with our partners in neighbouring areas, we are reviewing the extent to which all providers can meet the growing rate of births over the next 10 years. This will be a key part of the implementation planning.

The full details of the clinical model, investments and impact are in Part 3, Section 7.

\textsuperscript{55} Ambulatory care is emergency medical care (diagnosis and treatment) delivered to emergency patients who would have previously been admitted to a bed but are able to visit hospital and depart on the same day (with possible on-going follow up)

\textsuperscript{56} Future Hospital Commission 2014, Royal College of Physicians \url{www.rcplondon.ac.uk/projects/outputs/future-hospital-commission}
4.8 Transform the patient pathway and outpatients

The *Case for Change* identified that the current model of outpatient care is ineffective and outdated. It suggested that the system is wedded to a 20th century model of service, which is worsened by contracting arrangements and existing custom and practice. In addition to the finding that some appointments fail to add value for patients and clinical staff, without change there are expected to be an additional 141,000 appointments by 2020/2021, due to population growth. Giving the long waiting times that patients currently experience, no change is not an option.

Therefore in response, TST will transform the patient pathway and outpatients. Clinical leads have identified that around 20% of current outpatient activity is either unnecessary or could be provided in a radically different way. The quality of referrals will be improved to reduce unnecessary appointments and all possible pre-work will be completed in primary care. Skype and telephone clinics will become more widespread and in addition, where appropriate, primary care physicians will be given easier access to specialist advice through email and the telephone to help them give the right advice to patients without the need for a specialist consultation.

For the most common long-term condition pathways such as respiratory care and heart disease, we will build on the good work that has already taken place to improve diabetes care and redesign patient pathways in close alignment with each boroughs integrated care plans. In addition, prevention programmes will be strengthened to promote early identification, whilst tele-monitoring systems and patient initiated review (where patients have quick access to specialist opinion, when their symptoms get worse rather than through fixed appointments) will become more widespread.

For the most common planned care patient pathways (those that often result in an attendance at hospital for a procedure), care will be redesigned across East London to reduce waste and duplication. This will mean there will be standardised referral criteria, common standards of care and the widespread sharing of best practice across the region.

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

The full details of the clinical model, investments and impact are in Part 3, Section 8.

4.9 Reduce unnecessary testing

National evidence suggests that as much as 25% of pathology testing is unnecessary and recent audit work in City and Hackney CCG has suggested that as many as 20% of primary care initiated MRI requests could have been avoided. Our local analysis suggests that there is as much as 34% variation in the rate of pathology tests undertaken between East London CCGs, something that cannot be explained by population factors alone. Given East London CCGs currently spend around £42.5m per year on testing, as well as the importance of

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reducing waiting times for cancer testing by 2020, work to strengthen protocols represents a considerable opportunity for improvement.

Over the next five years, we plan to introduce a rolling programme of work focusing on the 20 most requested tests ensuring there are agreed protocols for testing in place between organisations across our health system. This will reduce the amount of instances where people are exposed to unnecessary testing and improve access to testing it is most needed. In addition, where testing is appropriate and it would reduce delays in the patient journey, we will build on the good practice we have already implemented to further enable GPs to book people into tests directly, without having to see a specialist first.

The full details of the clinical model, investments and impact are in Part 3, Section 9.

4.10 Deliver shared care records across organisations

Organisations across East London will further progress their plans to deliver shared care records. Without access to shared information, care professionals often need to repeat tests unnecessarily and ask repeated questions in order to properly diagnose and treat a condition. This is inefficient and leads to a poor patient experience. Access to a shared clinical record also reduces clinical risk as the full patient history (and proposed future appointments) is known; this allows a clinician to provide the most appropriate care.

To provide patients and care professionals with access to the right information, we will ensure that the IT systems that different health and social care organisations use can communicate effectively with each other (interoperability). Often this can be done through software that identifies and shares crucial data fields from the existing system, but it may mean organisations need to make decisions about the systems they would like to use in the future. The security of patients’ confidential information is of the utmost importance to all of us, so organisations will only share information with explicit consent except in an emergency situation (such as if a patient is unconscious). Patients need to have a say in how their data is used and continuing engagement with local residents will be important.

The full details of the clinical model, investments and impact are in Part 3, Section 10.

4.11 Explore the opportunity that physician associates may bring

Because our future projections show that GPs and specialist staff will be in even more finite supply, we need to diversify our workforce and make sure that we make the best use of the resources we do have.

The UK’s Competence and Curriculum Framework for the Physician Associate (2012) describes a Physician Associate (PA) as a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision. PAs can perform a large proportion of a doctor’s role at a reduced cost freeing up time for trained doctors to concentrate on providing more complex care. In primary care PAs can safely assume up to 83% of visits.

58 Investigating the contribution of physician assistants to primary care in England, Drennen et al, 2014
Because of the challenging recruitment outlook the future brings, exploring the opportunities that new roles can bring is fundamental to our sustainability. By 2025, we hope to have 85 PAs working in East London across both primary and secondary care.

The full details of the clinical model, investments and impact are in Part 3, Section 11.

**4.12 Develop a strategy for the future of Mile End hospital**

Barts Health has two acute inpatient wards at the Mile End Hospital (MEH) site which tend to act as overspill wards from the Royal London site. Clinicians have indicated that having these separate geographical locations leads to sub-optimal clinical practice, as it is difficult for consultants to provide the necessary oversight and clinical presence across these two sites.

Specifically, this lack of senior clinical input at MEH can result in patients not being reviewed and safely discharged in a timely way. As a result, patients often stay on the wards for long periods of time and are not always discharged home as soon as it is clinically safe to do so. Following the vacation of the acute inpatient services to the Royal London site there would be subsequent work to understand the opportunity this presents and how vacant ward space and the site as a whole could be better utilised to meet the needs of the rapidly growing local population in East London. Given a large percentage of the site is also used by East London Foundation Trust to provide mental health care, a joint site strategy would be developed for the future of MEH between Barts Health, East London Foundation Trust, Tower Hamlets CCG and other local stakeholders to determine the most appropriate long-term site plan.

The full details of the clinical model, investments and impact are in Part 3, Section 12.

**4.13 Define a strategy for the future of Whipps Cross**

Defining a strategy for the future of Whipps Cross University Hospital (WX) is crucial to the longer term sustainability of the local NHS. WX has been a pillar of the local community since the beginning of the 20th century, however there are significant challenges to address. Backlog maintenance (the investment Barts Health must provide to keep the current building safe for patient care) is high and the estate is not configured to deliver what is required for efficient, modern healthcare.

With things as they are, doing nothing is no longer an option. We are therefore developing a shared vision with our NHS and local authority partners. We want to write a new chapter in Whipps Cross' history, where we see it better meet the needs of local people now and into the future, by delivering better integrated services, improved clinical outcomes and a high quality of experience for all our patients.

Over the next six months, we will develop a Strategic Outline Case (SOC), which will set out all the scenarios and make a clear argument to take forward a course of action to deliver change. This may trigger the need for further work to specify how the strategy will be delivered (such as detailed designs for a major investment for example), and clarify how it would be funded. As a result, it may be some time, possibly years, before any change is seen on the ground. But it is important that we take the necessary steps to explore all opportunities and embark on this journey together.

The full details of the clinical model, investments and impact are in Part 3, Section 13.
5. Financial and activity assessment

Financial sustainability
The TST Finance Steering Group has defined reaching ‘financially sustainability’ as being when each organisation within the north east London health economy can credibly demonstrate a plan to meet statutory financial duties by March 2021. This definition excludes any requirement to repay provider deficits incurred. We recognise that to address the scale of the gap, a focus on new models of care delivery and new payment/commissioning mechanisms will be required for the overall system to reach balance.

For CCGs, financial sustainability means the recurrent delivery of a 1% surplus as required by NHS business rules. For providers, financial sustainability means recurrently delivering a surplus. In addition, because financial and clinical sustainability are intrinsically linked, all organisations in the system need to achieve their financial positions while meeting fundamental national waiting time standards and ensuring sufficient capacity exists in the healthcare system to meet demand.

The repayment of loans and other debts incurred in the process of reaching recurrent surpluses by 2021 has not been allowed for in the definition of financial sustainability. Organisations in north east London recognise that debt repayment is an issue that requires a consistent approach to be agreed.

Financial assessment
The TST programme has considered each initiative in the context of its impact on cost, price and activity; for example, initiatives that:

- enable a shift in activity from one care setting to another at a cheaper cost and reduced tariff, that also release capacity into the system
- increase productivity in the current care setting, thereby increasing capacity in the system, reducing average cost, but not price to the CCG
- do not directly impact on activity, but will incur costs/savings and are significant transformational change enablers.

All initiatives are still under development, and discussions regarding how any released capacity in all sectors will be utilised is currently being developed. Net savings and the system financial impact of the TST programme cannot be fully determined until these discussions are resolved. However, projected savings for the TST initiatives are expected to have a net beneficial impact of between £104 million and £165 million over five years to 2020/21. This is net of investment costs, and includes a capital requirement of £72 million. The expected annual recurrent net saving by 2020/21 is £43 million.

The table below includes sensitivity analysis, conducted in January 2016, of the changes the system will make. This helped identify the key variables that potentially impact positively or negatively on the net savings position, through a risk assessment of the key assumptions, resulting in upper and lower ranges.
In order to determine the financial impact of initiatives, the TST programme must consider the potential use of released system capacity. Capacity could potentially be reutilised by providers, enabling them to generate income to match, or improve services. Alternatively, capacity could reduce, freeing up resources and reducing cost within the system. Each option as to the use of capacity has consequences for activity throughput and for waiting lists.

In due course, all TST initiatives should be the subject of a business case before proceeding to approval in line with the governance arrangements agreed by the health system. At that point a decision will be made as to the use of the capacity that each TST initiative will release. This will enable the financial impact of TST initiatives on providers to be more accurately determined.

**Activity implications: bed availability**

Barts Health is currently running at or near 100% bed occupancy, with the prospect of further pressures as the WEL population grows.

By 2025/26, the local health economy will need an additional 550 beds based on 100% occupancy levels (200,000 bed days); however, this requirement reduces to 26 beds after 2020/21 and 240 beds by 2025/26 after the impact of the TST programme.

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Note: The expected benefits associated with Physician Associates have been recorded against the Primary Care transformational change. The acute benefits have not been linked to a specific transformational change, which by 2020/21 could result in net benefit of approximately £0.9 million/pa.
The table is based on an estimate of 2,019 beds currently available at Barts Health. More work is required to determine how the additional bed requirement will be met beyond 2020/21.

The impact of the TST programme by initiative on Barts Health beds

The above impact is based upon operating at 100% of capacity and shows that 2,045 beds would be needed by 2022 against a current available complement of 2,019\textsuperscript{60}, a 26 bed shortfall. Projecting below 100% occupancy would increase the bed shortfall.

\textsuperscript{60} Total bed numbers are calculated assuming full bed occupancy
Activity implications: outpatient activity

Although the bed requirement is of critical importance, we know that pressure also exists on outpatient activity as described in the charts below.

Outpatient appointments: Barts Health (all CCGs) ‘000s

A relatively small shortfall remains after the TST programme by 2025/26; however, there is an intervening period where the effect of TST initiatives outstrips growth and by 2020/21 there is a relatively small surplus of capacity compared to the baseline (43,000 outpatient appointments).

Activity implications: primary care

Without the TST programme or increases in capacity, demand growth for primary care creates a shortfall against capacity. This increases steadily so that by 2025/26 there is a shortfall against projected capacity of 24%. Assuming the same case mix, the impact of the TST programme reduces this demand above capacity to surplus capacity of around 560,000 appointments per annum. This ‘released’ capacity will be utilised by GPs spending more time with patients with more complex needs as a result of the projected move from secondary to primary care initiated by a number of the TST schemes.
Primary care appointments: capacity released (000’s)

Activity implications: Emergency and urgent care

Emergency demand will outstrip demand without TST, but the shortfall reduces when the effects of the programme are included. The urgent care programme will result in fewer people going to emergency departments.

Barts Health emergency attendances
Capital requirements

Capital costs identified as part of this programme are shown below. For comparison, we have also included the expected capital cost that the system would incur if the TST programme were not to be implemented and instead a new 550 bed hospital was built.

<table>
<thead>
<tr>
<th>£m</th>
<th>2016 to 2021</th>
<th>2021 to 2025</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Without the TST programme:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum costs of addressing essential IT and Estates Works in Primary Care and at BH</td>
<td>102</td>
<td>152</td>
</tr>
<tr>
<td>Cost of Redesign and complete rebuild of Whipps Cross site (to retain existing 600 beds)</td>
<td>41</td>
<td>453</td>
</tr>
<tr>
<td>Costs of building new Acute and Primary Care Facilities based on 550 beds</td>
<td>174</td>
<td>471</td>
</tr>
<tr>
<td>Costs of land for a new Acute Site</td>
<td>35</td>
<td>35</td>
</tr>
<tr>
<td><strong>Capital Costs without the TST Programme</strong></td>
<td>352</td>
<td>1,111</td>
</tr>
<tr>
<td><strong>With the TST programme:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum costs of addressing essential IT and Estates Works in Primary Care and at BH</td>
<td>102</td>
<td>152</td>
</tr>
<tr>
<td>Cost of Redesign and complete rebuild of Whipps Cross site (to retain existing 600 beds)</td>
<td>41</td>
<td>453</td>
</tr>
<tr>
<td>Capital costs of implementing TST programme</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td><strong>Capital Costs with the TST Programme</strong></td>
<td>173</td>
<td>636</td>
</tr>
</tbody>
</table>

Capital funding sources require further consideration and could include national bids or asset disposal across East London, plus a reduction in Barts Health backlog maintenance requirement if we go ahead with a rebuild at Whipps Cross.

The proposed development of Whipps Cross has been included in the list of TST initiatives. This initiative is not to be confused with backlog maintenance work for the site, which is included in the Barts Health baseline position. The Whipps Cross TST initiative involves defining a strategy for the future of the site. Capital design costs are estimated at £41 million and are included in TST initiative costs in the five year timeframe. Rebuild costs are estimated at £412m and are not anticipated until 2022. Should a rebuild be taken forward it is highly likely that the new building and associated flows will support a more productive hospital, these savings have not currently been quantified and would not be realised until well after the new building is operational. Were the redesign initiative to be implemented, we estimate that circa £40 million of capital costs currently included in baseline calculations for Barts Health backlog maintenance could be removed.
Capital impact of TST initiatives until March 2021

<table>
<thead>
<tr>
<th>Capital Required</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Closer to Home</strong></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>-</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>0.4</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>-</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Strong Sustainable Hospitals</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Care Hubs</td>
<td>9.3</td>
</tr>
<tr>
<td>Surgical Hubs, incl. IR</td>
<td>10.4</td>
</tr>
<tr>
<td>Normalising births</td>
<td>0.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>19.9</td>
</tr>
<tr>
<td><strong>Cross cutting themes</strong></td>
<td></td>
</tr>
<tr>
<td>Pathway redesign</td>
<td>0.7</td>
</tr>
<tr>
<td>Reduce unnecessary testing</td>
<td>-</td>
</tr>
<tr>
<td>Shared Care Records</td>
<td>9.7</td>
</tr>
<tr>
<td>Physician Associates</td>
<td>-</td>
</tr>
<tr>
<td>Mile End Hospital</td>
<td>-</td>
</tr>
<tr>
<td>Whipps Cross Hospital</td>
<td>41.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>51.3</td>
</tr>
<tr>
<td><strong>Net TST programme impact</strong></td>
<td>71.7</td>
</tr>
</tbody>
</table>

The method by which we have conducted our financial assessment are described in the end note.

Conclusions from modelled activity outputs

Our conclusions from the financial assessment undertaken so far are:

- The TST programme will significantly reduce hospital demand (before impact of population growth) at Barts Health over the next five to ten years.
- Inpatient and outpatient activity will reduce due to both preventative initiatives and initiatives that reprovide activity in alternative settings.
- The TST programme will reduce average length of stay, which supports the increase of productivity at Barts Health and reduces the need for additional beds at Barts.
- The TST programme predominantly impacts on activity for patients registered in East London. Additional capacity is required at Barts Health for other commissioned patients. There is a risk that the capacity released by the TST programme will be used for patients outside of East London.
- The TST programme moves us positively towards achieving both financial balance and meeting the need for more capacity to meet demand growth. However the delivery of provider cost improvement programmes, including productivity work, is a critical contribution to overall system financial balance and capacity release.
Further work required

In respect of the TST programme:

- We will critically review pricing and explore risk share possibilities and payment innovation. Further refining of investment costs especially in respect of workforce assumptions; estates requirements and delivery risks and phasing will be considered as part of implementation planning to determine that the assumptions for each initiative are robust.

- Providers will review each service line impacted by the TST programme so that the system can ensure that services remain both viable and sustainable, taking into account any payment innovation suggested as part of the TST programme.

- A joint commissioner and provider plan for use of the capacity released by TST programme needs to be agreed, aligned with our obligations of clinical and financial sustainability as a system.

- We will endeavour to understand the scale of elective waiting lists at Barts Health and understand how this might impact on the finance and activity projections.

- As part of implementation planning we will assuring that our community and mental health services have sufficient capacity to implement the new models of care.

- We need to agree the process for approving individual initiative investments to be released to proceed to implementation.

Outside of the TST programme:

- Barts Health cost improvement and productivity plans will be finalised and included in a wider five to ten year financial plan inclusive of the TST programme.

- NHS England’s success criteria for strategic plans, including the emerging Sustainability and Transformational Planning requirements, will be reviewed and responded to. The recommendations of the review of the financial assessment will be included in future iterations of financial strategy for East London organisations.

- The 2016/17 national tariff and planning guidance will be used to update plans.

- Specialist commissioning intentions will be obtained and incorporated into post-TST financial positions for the north east London health economy.

- Providers and commissioners will triangulate provider income and commissioner activity forecasts to ensure consistency of forecasting information and robustness of the baseline system financial plan.

- The final estates requirements, including capital investment costs, will be incorporated on the final publication of the Borough and WEL estates strategies, this will mean that the capital plans can be further detailed and funding sources identified.
6. Next steps

6.1 Delivery

The TST programme details 13 initiatives which have been grouped into three ‘clusters’:

- Care closer to home (CCH), which focuses predominantly on impacts to our community and primary care settings.
- Safe, sustainable hospitals (which focuses on acute care transformation).
- Working across organisations to continually improve care.

These clusters will require different approaches to implementation which are detailed below. It is important to recognise that across all initiatives strong clinical leadership and involvement in delivery is critical. The clusters will all be supported by the enabling work in Informatics, transforming the workforce for the future and estates.

Transformational change of mental health and children and young people’s services sit across clusters, and are involved in many of the individual key initiatives. They will require collaboration across organisations. The East London CCGs will be able to use the TST governance structure (detailed below) to track delivery and progress. A separate mental health strategy will be developed, in particular around the acute mental health services, and enhancing the mental health provision in primary care across the areas covered by four CCGs (Waltham Forest, Newham, Tower Hamlets, and City and Hackney) and two mental health providers (NELFT and ELFT).

There is still a lot of work to do as we move into the next phase of the TST programme. The strategic intent and outline plans laid out in this document must now be detailed for delivery and benefits realisation across the system in line with the Five Year Forward View. The next phase will utilise the working groups for the key initiatives already established by the programme.

Care closer to home

This strategy details the CCH outcomes and improvement frameworks, however it is the development of local delivery plans, led by the CCGs that will ensure the realisation of the frameworks.

There will be new contracting models that bring together CCGs and local authorities in the delivery of CCH initiatives. Future ways of working will see these emerging integrated provider organisations managing delivery of patient-centred care through a multi-disciplinary workforce.

CCGs will have responsibility for delivering the strategy through their local, borough-based, implementation plan including agreed outcomes and milestones. Activities that need to take place once across East London will be coordinated. A central team will also track progress and interdependencies of the local implementation plans, thereby providing an assurance function to the CCGs.

The central team will also be responsible for co-ordinating the necessary support for the CCGs from the TST enablers.
Increased access to primary care will be delivered through an East London improvement framework that is realised via local delivery. Urgent care will have a similar approach except for some aspects (e.g. NHS 111 procurement) that will require collaboration and governance across not just East London, but the whole of north East London. The end of life care initiative will continue to focus on supporting the implementation of the model of care, working predominantly with Barts Health.

The TST steering groups, detailed later in this section, provide the decision-making groups to further develop and deliver the transformational changes.

**Strong sustainable hospitals**

Delivery of the strong sustainable hospitals (SSH) initiatives will be predominantly led by Barts Health, with support and leadership from the across the CCGs. The TST programme will support the identification of required resources and support planning in this next phase. The SSH plans will need to be mainly site-led and managed, with interdependencies identified (including interdependencies with the CQC improvements and cost improvement plans).

The acute care hubs initiative and maternity initiative will see separate site implementation plans as the site reconfiguration and workforce will need individual delivery plans. However the surgical hub implementation plans will work across all the sites, with closely managed interdependencies. The SSH initiatives will sit within Barts Health’s existing governance structures and report to the SSH Steering Group and through to the TST Board, via the Clinical and Academic Strategy Board.

This cluster also needs to include and respond to:

- A clear vision and site strategy for Whipps Cross
- Impact of system changes such as the planned closure of the King George Hospital emergency department

For some changes proposed, or affecting, the SSH cluster (and the potential King George Hospital emergency department closure) the impact is across north east London and therefore the North East London Advisory Group will provide the forum for the wider discussions.

**Working across organisations to continually improve care**

These initiatives impact across organisations and therefore the TST governance is critical to their delivery.

The introduction of physician associates in primary care through the workforce initiative will be coordinated through TST and closely tracked through the workforce working group.

The shared care record requires coordination across East London, with local leads brought together currently by the East London chief informatics officer. An Informatics steering group is in place including multiple organisations.

Local estates strategies are being developed by each CCG and these are responding to the activity projections and TST care closer to home strategy. Making Whipps Cross fit for the future is a key TST initiative and the Whipps Cross strategic outline case is expected to be developed by June 2016. This will respond to the TST strategy and involve the local authority and others through the estates working group which reports to the TST board.
In addition organisational development and communications are areas of focus that will cut across all the clusters. All the changes required in implementation rely on staff co-creating, owning and leading the overall transformation process so its benefits are realised and sustained across the system. Therefore it is critical to ensure that organisational development is put in place to deliver the necessary change to organisations, clinical leadership and culture. Investment costs have been identified to support this.

**Governance of the TST initiative**

*Transforming Services Together* requires whole system working and collaboration to deliver the benefits. Our programme structure and governance is now aligned with these prioritised initiatives. This allows regular meetings between key decision makers to ensure rapid progress. The Care Closer to Home and the Strong Sustainable Hospitals clusters meet monthly – including representation from the programme management office, with key individuals attending both clusters to ensure alignment and direction. It is critical that the enabling areas support both clusters, and that the work across organisations is delivered. The TST Board oversees the whole programme.

As described above there will be some initiatives delivered locally through existing CCG governance and by local teams. There will also be initiatives delivered once across East London. For these initiatives the proposed governance structure is below and will be updated to ensure co-ordinated delivery.

For those initiatives that require north east London-wide collaboration and working, the existing forums of north east London advisory group (NELAG) and the clinical senate bring together commissioners and providers. The impact of the potential closure of King George Hospital emergency department and the maternity transformational change are specific examples of initiatives that impact the wider north east London footprint.
6.2 Implementation plan

These initiatives have been designed to be delivered in a phased and aligned approach over the next five years. As part of the next steps we need to engage and test our proposed changes with a variety of stakeholders ahead of the proposed implementation.

From March to June 2016 we will:

- engage with staff, stakeholders, patients and the public to test our proposals and develop our ideas. We also plan to consult on our proposals for surgical hubs
- develop implementation plans, identifying interdependencies
- strengthen the leadership and capability to deliver the next phase.

We will develop project initiation documents (PIDs) for implementation. PIDs are used to capture the initiatives approach and delivery plan. They will outline the resources, responsibilities and governance for each initiatives; define if business cases are required for funding (and which forum these will go to for approval); and capture key risks and issues for successful delivery.

Next steps
Communications and engagement

Communications and engagement have been an integral part of our work. During the engagement period we will be talking to overview and scrutiny committees, Healthwatch and our key stakeholders about how to ensure patients, the public and their representatives are involved in future. We will be publishing a summary version of this document, including a questionnaire, for distribution to a wider number of people across East London.

When we consider the results of the engagement:

- if there is general support and no significant, evidence-based challenge (ie. points that are backed up with firm reasons why our proposals are not the best), we will get on and implement them.

- if there are robust, evidence-based challenges to some of the proposals (ie. points that are backed up with firm reasons why our proposals are not the best, and preferably with sound alternatives) we will either incorporate these changes into the plans or consult formally on the ideas in order to reach a satisfactory conclusion.

- we will make a decision on the future of surgical hubs.

Whatever path is chosen for each element, we will ensure continued engagement of patients, the public and key stakeholders throughout the process. We will continue to test our plans with our patient and public engagement group, with local patient groups and
relevant specialty patient groups. We will report back to overview and scrutiny committees and the CCG and Barts Health governing bodies (as described in the previous section); these bodies include patient representation. We will monitor the engagement plan, and change it if necessary. For instance, if a proposal becomes more contentious whilst we are working up the final plan, then we might formally consult on the issue.

Engagement and consultation will be carried out locally where this is most appropriate (for instance primary care proposals) and across the whole of East London when the changes could affect this wider community. Locally, we will build our discussions into CCG and Barts Health engagement plans to discuss issues with local people. This will enabling the programme to better explain what proposals mean in each borough, reduce confusion and reduce the need for people to respond to multiple questionnaires.
End Note: Financial assessment methodology

CCG funding allocations have been based on recommendations issued by NHS England over the summer (2015). Funding growth estimates comprise both demographic and non-demographic components. Demographic rises are based on the Greater London Authority’s ward projections and non-demographic increases have been modelled at 2% a year. The pace of CCG funding allocations are expected to grow at a slower rate than demand growth.

Baseline positions
The financial starting point on which the TST programme has been assessed is based on the following:

- The expected baseline financial position of all North East London (NEL) organisations having taking into account estimated CCG funding growth allocations, 2015/16 plans, known local QIPP initiatives, and the impact of demand growth and cost inflation – this is the projected financial position if none of the TST initiatives were implemented.
- Any statutory, legislative or essential work that organisations need to carry out to estates, IT and workforce in Barts Health that has a cost requirement over and above that already included in their baseline plans.
- Inclusion of primary care co-commissioning funding budgets transferring to CCGs.

Quality, Innovation, Productivity and Prevention (QIPP) and Cost Improvement Plans (CIP)
East London CCGs have identified some firm QIPP schemes for 2015/16, but only Waltham Forest CCG has included a small value for defined QIPP schemes beyond that in the baseline positions. This is on the understanding that the TST programme will deliver the bulk of future QIPP savings in future years. Providers have included internal CIPs within their baselines where these are known.

Handling of surpluses and deficits
For CCGs, it is assumed that the TST programme impact on the carried forward surplus/deficit position at the end of each financial year is in accordance with NHS resource accounting and budgeting rules. For providers we have not carried forward in-year surpluses/deficits when calculating the five year local health economy deficit. This is in accordance with the planning guidance provided by North East London CCG Chief Financial Officers.

Modeled TST initiatives
The full range of TST initiatives impacts on a number of care settings, CCGs and providers. To enable a robust calculation of the impact of the TST programme, East London CCGs commissioned an activity-driven model that has the potential to interface with Barts Health modelling components to create a joint commissioner-provider model.

Key other methodological points
Where capacity is released within a provider as a result of an initiative, savings have been calculated by estimating the length of stay reduction and determining the number of new patients that could be treated using the number of days saved.

At a health economy level, changes between commissioners and providers within the same health system have a neutral financial impact as a tariff reduction is a gain to commissioners, but income loss to providers. Similarly increased income to a provider is a cost to commissioners. It is only when cost changes in an East London provider that there is a real net financial impact to the system as a whole.