Transforming Services, Changing Lives

The interim Case for Change
Foreword

We work in East London, one of the most vibrant communities in the world and we feel our population deserves the very best healthcare. This presents many challenges. We have significant deprivation, increasing long term conditions, such as diabetes, population growth and a growing population. There is increasing demand and expectation from patients. Whilst we have examples of excellent healthcare, there are services of variable quality in primary care, in the community and in our hospitals. Recruiting and retaining the skilled workforce we need is not easy and, although we have some of the most modern facilities in the country we also have many older dated facilities. Our organisations face considerable challenges going forward. These need shared action across the whole health and social care system.

The Transforming Services, Changing Lives programme has been established by commissioners and providers to enable us to jointly and positively plan for change and to address the shared challenges we all face. The development of this *Case for Change* is a key milestone. This document has been developed by clinicians working in East London and reflects our initial conclusions about the current state of local NHS services. It captures and celebrates the excellent services that we are delivering, but also identifies where we need to improve services and ensure we deliver best value for every £ spent on healthcare. **It will be the responsibility of us all** – local people, communities, local authorities, schools and the NHS to ensure a step change in our approach, that will enable the vision we have for improved health and the modernisation of healthcare services to be achieved.

This initial phase of the programme has been about much more than a document. The process of establishing the *Case for Change* has brought together healthcare professionals from a range of organisations and patient representatives, to share their expertise and knowledge, to create a community for change – people who are committed to improving care and ensuring the sustainability of local NHS services. This presents a unique and exciting opportunity.

We are delighted to share this *Case for Change* with local people and organisations who share responsibility for supporting good health and excellent healthcare services – in order to start a discussion on shaping how we work in the future. We look forward to hearing the views of the whole community, and particularly local people, who themselves have the responsibility to lead a healthy lifestyle and work in partnership with their healthcare professionals to maximise the effectiveness of care. We are very excited about taking forward these critical discussions within our community as the *Case for Change* develops over coming months.

**Sam Everington**  
Chairman of Tower Hamlets Clinical Commissioning Group

**Mike Gill**  
Associate Medical Director, Barts Health

Clinical leads for the Transforming Services, Changing Lives programme
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Executive Summary

• The NHS, its partners and stakeholders, staff, patients and public have developed this case for change. If we want to make good choices about the shape of the healthcare in future we must continue to work together
• High levels of deprivation, ethnicity, a mobile and growing population with limited budgets will continue to challenge the NHS and its partners
• We need a much greater focus on prevention and self-management of conditions
• There are many excellent services in east London, but there is significant variability and too many people have a poor experience and are not cared for well enough
• There is a difficulty in recruiting to some specialities. In future we will need new skills and roles (and therefore different training and education) to develop a modern workforce
• We need to recognise the importance of research
• The NHS must make better use of its resources (estate, finance, and the opportunities offered by modern technology)

There is a clear case for change, not just to improve existing services, but to ensure health and social care in east London continues to address the continuous challenges we face and take advantage of the regular opportunities for improvement.
About this document

Over 100 clinicians from NHS organisations in east London have worked together, with key partners and patient and public representatives to develop this document. Now we would like to hear your views, whether you work in the NHS, you live in or visit the area or you have expertise and knowledge that would be valuable to us as we develop our ideas.

There are a number of ways you can get involved:

• Look at further information on our website and take part in our survey: www.transformingservices.org.uk
• Get a copy of our summary document and fill in the questionnaire (available in libraries or by emailing us on tscl@nelcsu.nhs.uk or call us on 020 3688 1678)
• If you have a question, then please call or email us
• If you are part of a community group or organisation we would be happy to send a representative along to a meeting to explain and discuss the programme.

We are particularly keen to ensure we have a diversity of views so that our ideas are considered by a broad cross-section of the community.

We need to receive your thoughts and ideas by 21 September 2014 so that we can use them to inform the final Case for Change.
1. About Transforming Services, Changing Lives

Scope and approach
Transforming Services, Changing Lives aims to jointly develop plans to meet health and healthcare challenges and opportunities in East London

Programme aims

• To **improve services** and **health outcomes**
• To enable clinicians, commissioners, patients and providers to sustainably and **positively plan for change together**
• To develop a **clinically-led case for change** and a **clinical community for change** across East London
• To effectively meet the needs of **our complex population**
• Initial focus is on acute trust services, but looking across the whole system to identify where change is needed, including local authorities and public health.

Organisations

- **Acute trusts**
  - Barts Health
  - Homerton

- **WEL CCGs (Clinical Commissioning Groups)**
  - Newham
  - Tower Hamlets
  - Waltham Forest

- **Community and mental health trusts**
  - East London Foundation Trust
  - North East London Foundation Trust

- **Other commissioners**
  - NHS England
  - Barking and Dagenham; Havering and Redbridge CCGs
  - Local authorities

- **Patient and Public Reference Group (PPRG)**, consisting of representatives from Healthwatch, hospital and CCG patient groups
We are starting a journey to improve services for the whole community

Around 150 clinicians coming together to understand what challenges we face to create an interim *Case for Change*.

Engage with further 1,500 staff and public to produce final *Case for Change* (not solutions).

Explore and agree joint priorities to improve local services.

- Six Clinical Working Groups (CWGs) to consider clinical services
- Clinical Reference Group (CRG) to consider overarching clinical and demographic issues
- Patient and Public Reference Group to consider patient experience and priorities for change
- The programme sits alongside other CCG initiatives including integrated care, mental health and primary care transformation.

Informed by our programme principles:

- We will be courageous and we will trust, respect and challenge each other in developing the best options and solutions for the future.
- No change for change’s sake; we want to recognize areas of existing quality and best practice and build on these.
- We commit to listening to the patients’ and stakeholders’ voice and act on it.
- We will work collaboratively across providers, commissioners and different sites to ensure that overall healthcare system addresses our populations’ needs now and in the future.
- We will develop all our staff to maximize their potential and well being.
- We will develop innovative and efficient healthcare services that work for our population and for local people.
- We will communicate what we are doing and when key decisions will be made.
- We aim to develop a system that will move to best practice performance and ensure long term financial viability.

We are here

Publish Final Case for Change

April-June

July - Sept

Oct onwards
Six Clinical Working Groups (CWGs)

The CWGs brought together clinicians from across primary, community and hospital services to:

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

Interim reports have been developed for each CWG.

We have confusing and inconsistent models of care

There is not enough time and capacity, across all health and care services in East London, to deliver quality consultations for patients
Clinical Working Groups have considered national policies which set the overall direction for increasing quality and efficiency

For the NHS…

<table>
<thead>
<tr>
<th>Involving citizens in services design</th>
<th>Patients fully empowered in their own care</th>
<th>Primary care, provided at scale</th>
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</thead>
<tbody>
<tr>
<td>Modern, integrated care</td>
<td>Access to the highest quality urgent and emergency care, in line with emerging recommendations from the Keogh review</td>
<td>A step change in the productivity of planned care</td>
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<tr>
<td>Specialised services, concentrated in centres of excellence</td>
<td>A focus on quality and the governance of quality</td>
<td>7 day working priorities</td>
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<tr>
<td></td>
<td>Royal College and network recommendations for clinical services e.g. neonatal care</td>
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For mental health services…

- Ensuring mental health and physical health are recognised as inter-related and equally important
- All public services to reflect the importance of mental health in their planning
- Enable better access to mental health services with short waiting times
- Improve access to psychological therapies
- Introduction of a new national measure of wellbeing

For community health services…

- Community services need to be more closely connected to all other parts of the health and social care system
- Close alignment with the rest of the healthcare system will enable community services to be a driving force in improving the health of individuals and communities
- Community health services need to be much more closely involved in key decisions about patients at an earlier stage in their journey through the system

For social care services…

- The funding of social care is a significant issue. Over the past few years, there have been fewer people receiving funding for care
- The new Care Bill will raise the upper threshold for means testing and introduce a cap for private spending on social care – so people would otherwise have had to pay for care may qualify for social care support.
- However at the same time, in order to qualify for services, people will need to show a more significant need
- The impact on NHS services of more people receiving social care in their own home or a care home will need to be monitored, particularly in light of changes to allocations resulting from the Better Care Fund.
Barts Health and Homerton

### Homerton
General hospital (500 beds) with A&E/UCC (79,000 attendances), maternity (5,500 births) plus specialist care in obstetrics, neonatology, fetal medicine, fertility, bariatric surgery and neuro-rehabilitation.

### London Chest
Specialised heart attack centre and cardiovascular and respiratory centre (103 beds).

### St Bartholomew’s
Specialist centre for cancer, cardiovascular disease, fertility and endocrinology (250 beds). Minor injuries unit for non-emergency cases.

### The Royal London
Teaching hospital (747 beds) with a full range of general acute services, A&E/UCC (101,000 attendances), maternity (5,500 births) plus specialist services including paediatrics, obstetrics, neonatal critical care, major trauma, hyper-acute stroke care, cancer, neurosurgery, dental hospital.

### Whipps Cross
General hospital (589 beds) with A&E/UCC (112,000 attendances), maternity (4,980 births) plus some specialisms supporting the older population, including hyperbaric services.

### Newham University Hospital
General hospital (452 beds) with A&E/UCC (87,000 attendances), maternity (6,850 births) plus specialisms in fertility and diabetes.

### Mile End Hospital
Community hospital health centre providing a range of inpatient (64 beds) and outpatient services. These include family planning, termination of pregnancy and rehabilitation.
We also looked at the diverse range of primary, community and mental health services in East London.

Practices per borough ranges from 36 in Tower Hamlets to 61 in Newham, suggesting different primary care models with varying degrees of single-handed practices (6-29%).

There are also different models of mental health and community service provision e.g.

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

We are not making the best use of local health care services and resources.
Our vision for the best healthcare services in East London is an NHS which …

1. Improves health and prevents need for health services
   - The NHS working with an active local authority and voluntary sector to improve health, reduce health inequalities and prevent the need for health services
   - People are supported to manage their own health, self-care and use their NHS services appropriately – back-up by high quality and responsive primary care services

2. When need arises, ensures right care, right time, right place
   - Rare / dangerous / complex needs best treated by a specialist
   - Acute episodes of care treated efficiently according to severity / urgency
   - Long term conditions which are actively managed with patients to reduce the need for unplanned care

Specialised services
Local hospital services
Enhanced primary and community care services
Good health and experience of care for patients...

- Consistently high quality and efficient services

- Good patient experience and information
  - Individual services for patients, taking account of their own circumstances
  - Continuity of care – so patients do not have to constantly repeat their case history or repeat tests
  - Access to the right advice, test results and service, in the right place, first time
  - Being seen on time, given advice and kept updated
  - Staff friendly, welcoming and trustworthy
  - Getting an appointment quickly

- Supporting self management
  - Patients are equal partners in their own care
  - Use of technology such as text reminders about appointments and ability to book online
  - Non-judgemental advice to inform better health and good choices
  - Promotion of good mental health and access to appropriate mental health services when needed
  - Enough information and time to ask questions at a consultation.

Staff believe that good health can be achieved by ...

- Consistently high quality and efficient services

  - Good transitions between and within organisations with clear clinical responsibility in handover of care
  - Improved outcomes for patients by developing services which maximise the opportunities presented through new technology to deliver care in innovative ways

- Good patient experience and information

  - Effective IT systems that can communicate across organisations
  - Workforce that is happy, engaged and flexible in their working style, and which is supported by workforce development plans in each organisation

- Supporting self management

  - All services in the system working together and supporting good health: social care, schools, primary care, community care, mental health services and hospital care systems
  - Clear visibility of local services that are available, and consistency in the pathways of care
  - Open and honest discussions about variability in health outcomes and measures.

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.“ National Voices
Our initial work has identified a number of drivers for change …
2. Could the health of our population be improved?
We have some **innovative prevention and disease management services** in East London, but more needs to be done if we are to keep people healthy and manage their conditions

i) **The health of our population could be improved.** There are too many early deaths due to preventable diseases and other indicators of poor health are high. Key factors include high deprivation, rapid movement of population and a rich ethnic mix. This means that we need to go further than elsewhere in the country in our innovation and service improvement to address these complex needs

ii) These challenges will not go away as the **population is growing** at a faster rate than anywhere else in the country. The highest proportionate change is amongst the over 65s

iii) **Everyone has a responsibility for good health**, the NHS, local councils, health and wellbeing boards, businesses, schools, patients and the public.
Case study: High quality and innovative prevention and disease management

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

• one of the country’s best (top 10) services in Tower Hamlets
• London’s second best service in Newham
• the fifth best service in London in City and Hackney (and the best service in London for atrial fibrillation anticoagulant use)

This success has been supported by the Clinical Effectiveness Group based at Queen Mary University of London, which provide guidelines, education, data entry templates and other ‘on-screen’ supports with dashboard feedback on practice progress.

Footnote: Waltham Forest were not part of this original case study which was commissioned on an East London and City PCT basis. Data is not available for Waltham Forest from 2004/05 to 2010/11. For this indicator in 2011/12 Waltham Forest scored 89.59%, which ranked the PCT 100th out of the 151 PCTs in England. In London it was ranked 10th out of 31 PCTs. In 2012/13 Waltham Forest scored 89.46% for this indicator, which ranked the CCG 174th out of 211 CCGs nationally and 21st out of 32 CCGs in London.
The health of our population could be improved

- The age of the local population is relatively young so there is a low prevalence of diseases associated with old age: cancer; respiratory, cardiovascular and heart disease
- However there are inequalities – the population in the north of Waltham Forest is much healthier than in Tower Hamlets and Newham, where there is high early mortality. In these areas, although there are fewer people with life threatening illnesses, those people who are sick tend to have more severe health problems and a poorer prognosis.

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<th></th>
<th>Note</th>
<th>Newham</th>
<th>Tower Hamlets</th>
<th>Waltham Forest</th>
<th>Redbridge</th>
<th>City &amp; Hackney</th>
<th>England</th>
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<td>Early deaths - cancer</td>
<td>153.2</td>
<td>108.1</td>
<td>77.7</td>
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Significantly worse than the England average
Not significantly different from the England average
Significantly better than the England average

1. Years of life at birth; 2. Directly age standardised rate of deaths per 100,000 population aged under 75, 2009-2011

Source: Health & Social Care Information Centre
There are other health indicators that signify poor health

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**Significantly worse than the England average**

**Not significantly different from the England average**

**Significantly better than the England average**

1. Directly age sex standardised rate per % school children in Year 6 (age 10-11), 2011/12100,000 population, 2010/11; 2. Estimated users of opiate and/or crack cocaine aged 15-64, crude rate per 1,000 population, 2010/11; 3. % people on GP registers with a recorded diagnosis of diabetes 2011/12; 4. Crude rate per 100,000 population, 2009-2011; 5. Crude rate per 100,000 population, 2012 (chlamydia screening coverage may influence rate); 6. Still births and deaths <7 days per 1,000 births; 7. % school children in Year 6 (age 10-11), 2011/12
Factors contributing to the relatively poor health of the population

- Deprivation: the map shows (in brown) where households are amongst the most deprived in England. People living in poverty tend to have poorer health.

- Ethnicity and language: the map shows (in pink) the areas where more than 42% of the population are from a black or minority ethnic group. Many people in East London do not speak English as a first language. This adds to the complexity of delivering healthcare services.

- Population mobility: the East End is often the area where new immigrants move to first and then move on, so people and the ethnic mix of the population is constantly changing. This creates an administrative burden and challenges in providing continuity of care (particularly in General Practice). Continuity of care can be a problem with people moving in and out of the area, people often remain undiagnosed for long periods if they do not understand the NHS.

Whilst some poor health can be attributed to the variable quality of services, these factors also pose a significant challenge.

Alongside considering access to, and quality of, NHS services it is important that these factors are taken into account when we look at health outcomes and when we plan health and social care for the future.

We also need to look at our future population.
Population age and growth generates unique challenges

The average age of the population is low compared to most of England with 7.5% of the population aged 65 or over in 2011, but 20.5% aged under 15.

Over the next 20 years:

- The population of the three boroughs is set to grow by almost 270,000 (32%) – the equivalent of a new London borough
- Growth will be across all age bands but with the greatest increases amongst people of working age
- However the greatest proportional growth will be amongst the older age group; over 65s will increase by 37,000 (60%) and form 9% of the population.
- There will be 40,000 extra children in the three boroughs
- Neighbouring boroughs will also see high population growth: Redbridge (20%), Barking and Dagenham (34%), City and Hackney (24%).

Source: GLA projections (SHLAA model) 2013
Population growth will be predominately in Tower Hamlets and Newham

Experience has shown that demand for services tends to grow faster than the population. One reason for this is that the greatest proportionate growth will be in the over 65s, and older people are the largest users of health services.

Source: GLA projections (SHLAA model) 2013
Population growth will be highest in regeneration areas

- The map shows population growth over the next twenty years
- Darker brown areas indicate the electoral wards where growth will be highest, which is in regeneration areas such as the docklands and Queen Elizabeth II Park
- Just eight electoral wards will contribute 100,000 of the 160,000 increase in population forecast for the next ten years.

Our population is growing fast, and people move frequently, which puts pressure on local NHS services
Good health, excellent disease management and a speedy recovery if you become ill is everyone’s responsibility.

**Prevention**

- **Patients:** behavioural change and self-care
- **Schools, businesses:** health education, health promotion and early identification

**Improved health**

- **Local councils and public health:** housing, transport, quality of life and environment, health programmes

**Treatment and management**

- **NHS clinicians, healthcare assistants, therapists and other staff:** advice, early diagnosis and support to self-care
The NHS and patients have obligations under the NHS constitution

a) Patients have a right to:
- expect the NHS to assess the health requirements of the community and to commission and put in place services to meet those needs and improve the health of the local community
- access, without discrimination, the vast majority of NHS services free of charge – some within maximum waiting times; and go to some other European countries for treatment

However we know that:
- sometimes the NHS relies on an over-medicalised and paternalistic model that seeks to “fix” patients rather than empowering them to make choices about health and healthcare; sometimes people wait too long.

b) Patients have an obligation to:
- recognise the contribution they can make to their own health and provide feedback on services
- register with a GP practice
- participate in important public health programmes such as vaccination and provide accurate information about their health, condition and status
- keep appointments, or cancel within reasonable time, and follow an agreed course of treatment and talk to clinicians if this is difficult
- treat staff and other patients with respect

However we know that:
- half of medication prescribed for long term conditions is not taken or not taken as prescribed
- 5-10% of people do not attend their GP appointment; for hospital outpatients it is c19% (above the national average)
- MMR vaccination rates range from 72% in Newham to 93% in Tower Hamlets
- In 2013, 12% of Barts Health and Homerton staff, 13% of NELFT staff and 22% of ELFT staff reported experiencing physical violence from patients, relatives or the public in the last year.
3. Do all patients benefit from a consistently world class service?

Assessing the current service
A world class service: Summary

We have some world class services, but not every service is excellent all the time:

i) Patient experience is often poor

ii) Services are of differing quality depending on whether the patient is the focus of integrated, acute, social and mental health care and:
   - where they live
   - what service they need
   - what time of the day or week they need care.

We also need to recognise the critical importance of research in developing new, cost effective solutions to improve patient safety and experience.

N.B. This section summarises the work of the Clinical Working Groups. More detail is available in the CWG reports and data packs available on the website or by phoning/emailing.
Social prescribing, a scheme that links patients with non-medical sources of support in the community, is being used effectively in Tower Hamlets to provide preventative care in partnership with the voluntary sector.

Barts Health and Homerton consistently achieve the national target to complete tests within six weeks’ of referral. On average 100% of C.Difficile tests are completed in four working days and 99% of HIV antibody tests in three days.

The Barts Health clinical biochemistry team recently won the national Patient Safety in Diagnosis Award.

In Barking and Dagenham, Havering and Redbridge, GPs use individualised patient scorecards to support patients suffering from chronic obstructive pulmonary disorder (COPD) and help them manage their condition.

The children’s hospital at Barts Health offers a wide range of regionally specialised medical and surgical services including paediatric intensive care within close reach of children of East London.

GPs in Waltham Forest can now test for heart failure using B-type Natriuretic Peptide (BNP) testing, saving patients a trip to the hospital.

Doctors at the London Chest recently injected a patient’s own stem cells into his heart at the start of the world’s largest-ever trial of adult stem cell therapy – aimed at reducing deaths from heart attacks.

Whipps Cross has an emergency gynaecology unit, to provide one-stop diagnosis. This has halved emergency attendances and reduced waiting time breaches by 80%. Patients now wait less than 48 hours for ultrasound diagnosis, and there has been an 84% reduction in complaints.

The Royal London Hospital’s hyper acute stroke unit and Whipps Cross and Newham’s stroke units provide patients with some of the best care not only in London but across the country.

The Care Quality Commission assessed Homerton’s A&E services as outstanding.

Whipps Cross use evidence based techniques such as fetal fibronectin and transvaginal cervical scans to identify women who may in the early stages of labour, which reduces unnecessary transfers and stays in hospital.
More can be done to improve patients’ experiences

- In London, **GP patient satisfaction** scores are low for access; seeing a GP of choice; getting through on the phone; and booking ahead. No CCG in East London meets the England average for patient satisfaction.

- **Patient experience of acute care** services in East London is low. Barts Health has lower than national average scores on inpatient, A&E and combined friends and family scores. The biggest variation is in A&E where Barts Health scores 48 compared to a national average of 57.

- Out of 22 London hospital **maternity services**, Barts Health is ranked 19th and the Homerton 21st (Care Quality Commission, 2013), although a recent CQC inspection of maternity services at the Homerton rated the services as good.

The Royal London lost my files which meant according to their system my baby wasn’t born and I was forced to stay in the hospital for an extra night

I waited four days to be discharged from the hospital and there was nothing wrong with me

I would like to see someone take overall responsibility for my care…whether that is a GP, a nurse, a consultant…I just need some help pulling it all together

<table>
<thead>
<tr>
<th>Satisfaction with General Practice using NHS Outcome framework indicator: “Patient experience of GP services, percentage whose experience is very good or fairly good.”</th>
</tr>
</thead>
<tbody>
<tr>
<td>England average</td>
</tr>
<tr>
<td>City and Hackney CCG</td>
</tr>
<tr>
<td>Barking and Dagenham CCG</td>
</tr>
<tr>
<td>Tower Hamlets CCG</td>
</tr>
<tr>
<td>Waltham Forest CCG</td>
</tr>
<tr>
<td>Newham CCG</td>
</tr>
<tr>
<td>Redbridge CCG</td>
</tr>
<tr>
<td>England worst</td>
</tr>
</tbody>
</table>
Services in a primary care setting

NHS England has a vision for General Practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better outcomes, more personalised care and excellent patient experience. However there is also a call for reform which:

- takes care to build on the strengths of General Practice through registered lists, generalist skills, management of long term conditions and highly systematic use of IT
- looks at opportunities of working at greater scale to support better access to convenient and reliable unscheduled care as well as coordinated and high quality continuity of care which is efficient and financially viable.

Primary care services are facing unprecedented challenges

- Funding in General Practice has been relatively flat with, nationally, a real term decline in investment over the last two years. Locally this position is even more challenging due to rapid population growth and a ‘lag’ in funding following population growth. As with the rest of London, spend on primary care in East London is low (in the lowest 25% nationally)
- GPs report unprecedented levels of demand. Local doctors believe that patients with complex needs require more than a 10 minute consultation, and this cannot continue if we are truly committed to high quality care and delivering more care, closer to home. Addressing this is a major challenge within current resources and requires transformational change.

In addition to these financial and capacity challenges, there are variations in the quality of General Practice services

- There are a significant number of GP practices in East London which do not meet the GP Outcome Standards. (These standards cover a range of services provided by general practice, such as screening, diagnosis and patient experience, and represent a level of care everyone should expect to receive from their GP surgery). Results can be seen on www.myhealth.London.nhs.uk
- There are significant variations in achievement against the Quality and Outcomes Framework indicators, for example in how well practices are identifying people who are at risk of a chronic disease
- East London has more than the national average of ‘small’ General Practices (one or two GPs).
- East London has a high level of A&E attendances, except for Waltham Forest which is below the national average. This indicates a lack of access to General Practice. Access to GP services is poor (the bottom 25% nationally) for every CCG as measured by the GP patient survey.

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

Variance in the expected against actual prevalence of Coronary Heart Disease 2012/13 (Lower variance is better)
Maternity services

The Clinical Working Group has proposed four key principles of “what good looks like”:

• We are far from our aspiration of providing 95% of antenatal care (or 16,200 pathways) outside of hospitals

• The number of pregnant women having their first antenatal assessment by 13 weeks (the national target) ranges from 63.9% to 96.1% across East London boroughs, against a national average of 86.2%. This means that risks are not being identified and managed early enough

• We want to see increases in the levels of midwife led care.

• We expect the number of births in East London to continue to grow. Ensuring there are sufficient doctors and midwives as well as the appropriate space will continue to be a challenge. There is currently sufficient space to operate at safe capacity levels but this will become a pressure as births increase. No hospital in East London meets the London quality standard of 168 hours (24/7) obstetric presence on-site – although no Trust in London meets this standard. There is 70 hrs per week consultant presence at Newham, 74 hrs per week at Whipps Cross, 71 hrs per week at the Royal London and 98 hrs per week at the Homerton. There would be significant cost and recruitment pressure to achieve these levels. For midwife ratios, the London quality standard is a minimum of 1 midwife for every 30 births per year. The Royal London, Newham and Whipps Cross do not currently meet this standard.

• There are variations in service activity, which may indicate a lack of consistent pathways and protocols. Caesarean section rates vary from 27.0% to 29.5% and intervention rates during labour vary from 4.7% to 13.7%. This variation will be influenced by protocols and clinical decision making. Intensive care cot activity across Barts and Homerton has risen by 11% (2011/12-2013/14); High dependency activity has increased by 1.5% and special care activity has fallen by 8%. There are challenges in ensuring appropriate staffing levels to respond to these trends.
The Clinical Working Group has put forward a proposal for key principles of “what good looks like”:

**PRINCIPLE 1**
Seamless transitions of care

**Varying cut-off and acceptance ages for different services and providers** can result in staggered and overly complex transitions across different care pathways for children and young people with complex needs. For children with multi-professional contact, transitions are not joined up enough with a lack of professional responsibility for co-ordinating the care and the transition. This can result in poor patient experience and gaps in service provision.

**PRINCIPLE 2**
Integration of community care

Young people (adolescents) are being treated in inappropriate settings, both paediatric and adult. Young people with long term conditions are not being consistently well supported into adult services. This does not meet best practice standards and brings quality concerns and lower patient satisfaction.

**PRINCIPLE 3**
Consistent hospital care pathways

Children and young people with complex needs are given lots of appointments with a large number of teams to deal with a set of issues and with little coordination.

**PRINCIPLE 4**
High quality and appropriate urgent care

Children and young people are not having mental health conditions identified and effectively managed quickly enough. There has been a rise in the levels of self-harm by children and young people and services are not consistent in picking up and responding to underlying mental health issues. Emergency hospital admission rates with a self-harm diagnosis rose 13% between 2007/08 and 2013/14.

We do not have effective care networks for specialist care, medical care, elective surgery and emergency surgery, as recommended by Health for North East London. With a lack of visible, standardised pathways and protocols we cannot be confident that all children and young people are given equal access to care.

There is a variation in models of urgent care. Whipps Cross is the only site where all emergency admissions are seen and assessed by the responsible consultant within 12 hours of admission. Paediatric surgical and anaesthetic expertise is not provided across all sites.

There is high variance in non-elective admission rates: The graph shows that children from Waltham Forest are much more likely to be admitted to hospital than children from Newham or Redbridge. We need to understand why we are seeing these differences.
Mental health services
The overall aims and vision for mental health services in East London:

- To work together with partners to promote mental health and well-being in our communities
- To prevent residents from developing more significant mental health problems
- When people do need them, mental health services are of the highest quality, proactively supporting people to recover

Delivery against the National Outcomes Framework for Mental Health contained in No Health Without Mental Health

• There are very high levels of mental illness in East London, with very high demand for child and adolescent mental health services, mental health services for adults of working age, and mental health services for older people including dementia. This may be influenced by the fact that East London has a high prevalence of risk factors that can contribute to the development of mental health problems in individuals.

• Many people with long-term physical health conditions also have mental health problems and having mental health problems can exacerbate a physical illness. This can lead to significantly poorer health outcomes and reduced quality of life. In addition, people with a primary mental health need can have their physical health needs overlooked. Total health care costs are increased by at least 45% for each person with a long-term condition and co-morbid mental health problem (Kings Fund 2012). Physical health outcomes for people with mental health problems in East London are poor, and mental health problems are a significant risk factor for acute hospital admission in people with complex co-morbidities.

• There is a high proportion of adult service users in touch with secondary care mental health services; a high number of people on the Care Programme Approach; a very high number of emergency admissions for psychosis; and high prescribing rates of anti-psychotics and anti-depressants. We have a comparatively high proportion of people with depression, a very high incidence of first episode psychosis, and a very high incidence of psychosis.

• Transitions for young people into adult services, which happens at 18 years old, regardless of individual needs, are often poor and can lead to people who need mental health services falling out of the system.

• Significant proportion of mental health patients being admitted as an emergency at Barts Health (third highest reason for admission – 2,138 emergency admission in 2013/14), many of which are for an alcohol related diagnosis.

• We need to get better at Improving Access to Psychological Therapies (IAPT) and in the diagnosis and treatment of dementia. National guidance expects a 15% IAPT rollout and a recovery rate of 50%. Dementia services are a key component of integrated health and social care services, supported by accountable professionals.

% breakdown of Mental Health Primary Diagnosis comparison between alcohol related and other primary diagnosis by site, 1st October 2012 to 30th September 2014

<table>
<thead>
<tr>
<th>Hospital</th>
<th>TOTAL ADMISSIONS</th>
<th>No with an alcohol related diagnosis</th>
<th>No with other Mental Health primary diagnosis admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>BARTS AND THE LONDON NHS TRUST</td>
<td>1,033</td>
<td>1,105</td>
<td></td>
</tr>
<tr>
<td>WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST</td>
<td>331</td>
<td>489</td>
<td></td>
</tr>
<tr>
<td>NEWHAM UNIVERSITY HOSPITAL NHS TRUST</td>
<td>199</td>
<td>406</td>
<td></td>
</tr>
<tr>
<td>HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST</td>
<td>203</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>BARTS AND THE LONDON NHS TRUST</td>
<td>200</td>
<td>126</td>
<td></td>
</tr>
</tbody>
</table>
Services for people living with long term conditions

The Clinical Working Group has put forward a proposal for key principles of “what good looks like”:

- **PRINCIPLE 1:** A high quality, interdisciplinary coordinated care approach is the norm
- **PRINCIPLE 2:** People supported by professional to live healthy lifestyles and empowered to take an active role in their care
- **PRINCIPLE 3:** Primary care-based teams proactively coordinate care, pulling in specialist expertise when necessary
- **PRINCIPLE 4:** Specialists support delivery of a model of care at or as close to home as possible
- **PRINCIPLE 5:** Care addresses the mental and physical health care goals of individuals
- **PRINCIPLE 6:** People in the last years of life are supported to transition into palliative care

A greater emphasis on the prevention of LTCs and promoting healthy lifestyles underpins the care of those with long term conditions

- In investigating the current position against these principles, the CWG found examples of excellent practice, but also examples that demonstrate a lack of active management by health professionals, support for self-management and proactive coordination
- Local clinicians believe, **current services for people with long term conditions are not sufficiently flexible and responsive** to the needs of patients. The service model and resources operate on a model of providing routine three-monthly appointments, which do not have a clear objective for the patient. We need our planned care services for people with long term conditions to be able to respond to people in an urgent situation and add value in a planned care setting
- **Too many cancers are being diagnosed through an emergency route** indicating potential for improvement in a primary care setting. Waltham Forest has the second highest rate per 100,000 population in London for breast and prostate cancer diagnosed in the emergency route; Barking and Dagenham has the second highest rate diagnosed in the emergency route per 100,000 population in London for lung cancer and the third highest rate for colorectal cancer in London.

- Opportunities to better manage long term conditions are indicated through the **large variation in emergency admissions and emergency bed** days for conditions such as asthma and diabetes (see table). Locally, Waltham Forest has the highest proportion of emergency bed days compared to the other CCGs in East London.
- Clinicians believe that care planning should be the cornerstone of long term condition care, yet on average **91% of patients in East London responded “no” when asked whether they had a written care plan** (GP Survey, 2014).

<table>
<thead>
<tr>
<th>CCG</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>City &amp; Hackney</td>
<td>251</td>
</tr>
<tr>
<td>Tower Hamlets</td>
<td>566</td>
</tr>
<tr>
<td>Redbridge</td>
<td>961</td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td>1,206</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>904</td>
</tr>
<tr>
<td>Newham</td>
<td>481</td>
</tr>
<tr>
<td>England Average</td>
<td>795</td>
</tr>
</tbody>
</table>

Unplanned admissions for Ambulatory Care Sensitive conditions - Age standardised rate per 100,000 population

Indicates that the CCG’s performance is higher than the England median

Indicates that the CCG’s performance is lower than the England median
Unplanned care services, for adults and children

The Clinical Working Group has put forward a proposal for key principles of “what good looks like”:

- **PRINCIPLE 1:** Promote planned care to help prevent unplanned contacts where they are avoidable
- **PRINCIPLE 2:** Support people with urgent care needs to get to the right advice, in the right place, first time
- **PRINCIPLE 3:** Ensure services for urgent, non-life threatening needs are delivered at or as close to home as possible
- **PRINCIPLE 4:** Serious or life threatening needs should be treated by experts in the best facilities to reduce risk, maximise survival and improve recovery
- **PRINCIPLE 5:** Care should be delivered as a connected model of urgent and emergency care

 Supported by education, training and development and integrated IT systems

Financial incentives to drive best practice

- **We have a high use of unplanned care services, particularly A&E.** Evidence suggests many attendances could be managed well in alternative settings. Newham’s Urgent Care Centre found 30-40% of people attending could be cared for closer to home.
- **There is variation in emergency admissions rates** (94.5 per 1,000 population in Tower Hamlets to 114.9 in City and Hackney).
- **Performance against the target that 95% of A&E attendances are seen and treated within 4 hours varies across sites:** Royal London 93.7%; Newham 97.35%; Whipps Cross 93.77% and Homerton 96.1% (2013/14 all types).
- **There is significant variation in the number of ambulance handovers that breach the 30 minutes standard,** ranging from three breaches at the Homerton to 460 breaches at Whipps Cross (April 13–Jan 14).
- **We see variation in some clinical indicators.** The biggest reason for delayed transfers of care at Homerton is people awaiting care packages in their own home. At Barts Health completion of assessment is the biggest reason for delayed discharge. Compared with national measures, we have too many emergency readmissions; readmission rates of mental health patients are high, except for Newham where they are low.
- The Royal College of Surgeons (2011) identified a two-fold variation in deaths following emergency surgery in hospitals in England and Wales. Their report sets out recommended standards to improve care and outcomes. Further work is required in East London to assess how well we are meeting these standards. This work will be undertaken over the summer and findings will be included in the final case for change. Development of surgery specialisation, for example breast, is depleting general surgery skills. This has implications for the way we deliver emergency surgery.
- Not all sites meet the London Quality Standards for all emergency adult surgery admissions to be seen and assessed by a relevant consultant. **None of the Barts Health sites meet the standard for all emergency admissions for fractured neck of femur** to be seen and assessed by a consultant geriatrician/physician and a consultant anaesthetist within 12 hours.
Planned surgery services

The Clinical Working Group has put forward a proposal for key principles of “what good looks like”:

- **PRINCIPLE 1:** Appropriate access to high quality surgery
- **PRINCIPLE 2:** Appropriate preoperative care closer to home
- **PRINCIPLE 3:** Separation of elective and emergency surgery
- **PRINCIPLE 4:** Day cases as the norm
- **PRINCIPLE 5:** Safe care, in the right place at the right time
- **PRINCIPLE 6:** Coordinated reablement and recovery

**Supported by:** Informed patient choice, a good understanding of capacity and demand, a skilled well-developed and motivated workforce, integrated care pathways and the latest developments in technology

**Underpinned by:** Shared clinical responsibly for the patient along the whole pathway

- There is a **variation in planned surgical spells**, potentially indicating variation in access arrangements. This may in part be driven by differences in population health need, but may also indicate variations in clinical practice. In one year, taking into account the size and age of the population, there were 10,646 planned care spells in Tower Hamlets and 12,786 in Newham (per 100,000 population, age adjusted).

- Evidence suggests that for some specialties, **consolidation of services leads to improved efficiencies and outcomes**. In other cases it may be better and possible to deliver services more locally. Clinicians in the group feel that there is an opportunity to **strengthen local surgical and clinical offerings**, while achieving better outcomes by agreeing where and when specialised delivery would be most effective. However, any changes must take into account that surgery currently underpins the local delivery of A&E, maternity and paediatric services. The effect of these interdependencies needs to be fully understood and mitigated to ensure the provision of a functional local hospital based on population needs.

- We know that **people are receiving variable standards of care**. Currently Referral to Treatment Times (18 week standard) performance varies across the patch and across specialties - Barts Health underperformed with 82.55% (failing to achieve the 90% standard in nine specialties). The Homerton achieved the standard with 91.47%.

- **Too many patients are having their operations cancelled:** Cancellations range from 10% in one specialty to 1.1% in another.

### Barts Health Trust: Referral to Treatment (18 week) Performance

<table>
<thead>
<tr>
<th>CCG Name</th>
<th>Treated within 18 weeks</th>
<th>Greater than 18 weeks</th>
<th>Total</th>
<th>% within 18 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newham CCG</td>
<td>714</td>
<td>144</td>
<td>858</td>
<td>83.2%</td>
</tr>
<tr>
<td>Tower Hamlets CCG</td>
<td>561</td>
<td>149</td>
<td>710</td>
<td>79.0%</td>
</tr>
<tr>
<td>Waltham Forest CCG</td>
<td>521</td>
<td>118</td>
<td>639</td>
<td>81.5%</td>
</tr>
<tr>
<td>Redbridge CCG</td>
<td>274</td>
<td>49</td>
<td>323</td>
<td>84.8%</td>
</tr>
<tr>
<td>City &amp; Hackney CCG</td>
<td>145</td>
<td>57</td>
<td>202</td>
<td>71.8%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>718</td>
<td>103</td>
<td>821</td>
<td>87.5%</td>
</tr>
<tr>
<td><strong>Total Barts Health Trust</strong></td>
<td><strong>2,933</strong></td>
<td><strong>620</strong></td>
<td><strong>3,553</strong></td>
<td><strong>82.5%</strong></td>
</tr>
</tbody>
</table>

Target is for 90% of patients to be treated within 18 weeks of the data of referral
Clinical support services: The Clinical Working Group has put forward a proposal for key principles of “what good looks like”:

- PRINCIPLE 1: Ensuring enough capacity to meet growing demand
- PRINCIPLE 2: High quality access to services
- PRINCIPLE 3: Clear and robust pathways of care
- PRINCIPLE 4: High quality and high performing services

Population growth and the growth of the number of people with long term conditions is a major factor in the demand for Clinical Support Services

- At the rate our local population is growing, we will require an estimated two million (10.6%) extra tests between now and 2020/21
- Capacity will be tested further through a projected increased in the prevalence of some long term conditions and a drive for earlier identification of these conditions

The current solution is to increase resources – which is not a financially viable long term option. An important role for clinical support services in addressing this increased demand will be to support clinical services in accessing testing and diagnostic procedures in the most appropriate way

In terms of performance, we are seeing variation in turnaround times in clinical support services particularly for high volume disciplines such as haematology and clinical biochemistry

In relation to robust care pathways, the London Quality Standard sets out that access to Interventional Radiology should be available 24/7 and for critical patients within 1 hour, and 12 hours for non-critical patients. Only the Royal London Hospital meets this standard of care – which clinicians report is driven by a lack of robust network arrangements and care pathways

There are delays in the ‘examination to report’ and ‘report to referrer’ parts of the pathway. Evidence suggests there are unacceptable numbers of patients breaching the six week target. This is exacerbated by lack of consultant radiologist cover and a lack of oversight of the end-to-end pathway. GPs report IT constraints across organisations, which results in chasing test results, and increased costs due to duplicating tests.

Access to new technologies and treatments needs to be balanced with an assessment of appropriate use and consolidation of services.
The quality of some care is not the same 24/7

NHS England estimates that over 500 lives could be saved a year in London if patients admitted in an emergency at weekends had the same standard of care as patients admitted on weekdays. Effective seven day working will require a system wide approach across the healthcare economy if we are to realise the vision of consistent high quality health care delivered 365 days a year 24 hours a day (when clinically needed).

People often ‘default’ to A&E out of hours. Not only is it trusted, the service is highly responsive and easily accessible, with an average wait nationally of 50 minutes and the vast majority of people seen and treated within four hours. The 24/7 primary care model is delivered through GP out of hours services, but there is currently limited infrastructure to support GPs to deliver effective care out of hours.

Effective seven day working would enable the delivery of:

• the same standard of urgent and emergency services, whether provided in or out of hours, in primary, community and acute care settings
• services in the most appropriate setting, reducing the (often perceived) need for people to travel to an A&E, and patients to be being discharged home at the appropriate time.

Achieving a seven day service will require a transformational shift in care involving:

• increased resourcing for community based services and social care services, particularly looking at opportunities created through the Better Care Fund to support seven day discharge
• increasing primary care access. CCGs are exploring network models to achieve this
• additional consultant appointment and reorganisation of the existing consultant workforce. This should include looking at options for more consultants with the skills to manage patients across different speciality areas (‘generalists’) to increase the flexibility of the consultant workforce delivering daily reviews at weekends.

Key issues that the healthcare system will need to consider are:

• in which services would quality improve if we introduced a 24/7 service?
• costs and resources; staffing and training – how many 24/7 services can we safely support in East London?
• the need for clinical support services to ensure effective operation of a 24/7 approach
• the impact and interdependencies with the rest of the care pathway.
Case studies: seven day services

The Adult Respiratory Care and Rehabilitation Service in Tower Hamlets (ARCaRE) has brought together community, early supported discharge and pulmonary rehabilitation teams to deliver a seven day model of care and expertise. This reduces weekend admission of patients and supports weekend discharge after patients have been in hospital.

Unusually for the NHS, heart attack patients at The London Chest Hospital are as likely to survive at the weekend and out of hours as those admitted during “normal” working hours thanks to round-the-clock consultant-led care.

By providing quicker access to consultants; short stay observations and assessment; and care at home – provided by a seven day a week community children nursing team, the children’s service at Homerton has reduced:

• length of stay in hospital
• the number of times patients need to attend
• the rate of readmissions.

The hospital has also developed a ‘virtual ward’ for children with complex needs, providing a range of services by clinicians working together in the community.
4. How sustainable is our workforce model?
Our current workforce: Summary

Whilst there are examples of leading edge schemes to build a sustainable, flexible, professional workforce, there are challenges in recruiting for specific posts in both primary and secondary care, which reflects the national experience.

There are additional issues in East London, in particular due to the high cost of living and variations in cost of living allowances. We need to work closely with local authorities as recruiting a local workforce is essential to delivering appropriate care.

We need to:

i) address the current challenges and workforce gaps

ii) ensuring our workforce have the skills needed to deliver the model of care in the future

iii) ensuring our workforce is engaged, flexible and motivated to be able to deliver high quality patient care and innovate to support continuous service improvements

iv) recognise the importance of clinical leadership in driving improvement.
Case studies: we have some excellent workforce models

Barts Health is a major employer. Nearly **40% of staff live in East London** and the trust is increasing the recruitment of local people by:

- direct and reserved access to entry level jobs for people who are unemployed in East London
- job readiness assessment and support
- apprenticeships which lead to permanent jobs.

Between April and Dec 2013, 75 candidates were placed. As well as apprentices in theatre support, admin and laboratories, new roles will be started in maintenance and a pilot for healthcare assistant roles in outpatient department settings.

Barts Health has moved from the traditional concept of vacancy rates to focussing on ‘fill rates’. This involves forecasting recruitment needs over a the year, based on turnover (both leavers and internal moves/promotions), predicted service changes and staffing pressures such as maternity leave. Approval to recruit is undertaken in bulk, contributing to a more efficient process.

This has enabled the trust to reduce their time to fill rate (e.g. date of instruction of the vacancy to unconditional offer of employment) from 18 to eight weeks. Patients benefit from improved quality and continuity of care as reliance on agency/bank staff reduces.

At Homerton, 83% of staff agree that “**Care of patients / service users is my organisation’s top priority**”. This is against a national average of 68%.

The Barts Health ‘Community Works for Health’ programme seeks to recruit a **culturally and linguistically sensitive workforce**. This improves patient care and helps the Trust’s understanding of, and response to, the needs of patients.

Tower Hamlets operate an innovative network system. These bring together **GP practices to work collectively to manage long-term conditions** and other services with shared incentives and outcome measures.

The networks have developed a more cohesive primary care community and reduced variation in quality, for example in diabetes care and childhood immunisation performance.
We have existing gaps in the hospital workforce

• The existing staff structure doesn’t enable a high quality service
  • Adult emergency surgery: we do not meet requirements for all emergency admissions to be seen and assessed by a relevant consultant within 12 hours
  • Emergency admissions: for fractured neck of femur, no Barts Health site ensures all patients are seen and assessed by a consultant orthopaedic surgeon within 12 hours

• Even where the staff structure may be appropriate, we sometimes cannot fill the posts. Despite a range of initiatives to recruit and to retain staff, there are some posts that are difficult to fill and some areas that have national and local shortages. There are particular challenges in recruiting:
  • A&E consultants
  • paediatric nurses
  • neonatal nurses
  • midwives.
We have existing gaps in the primary care workforce

- There are significant challenges in recruiting practice nurses and district nurses. This pressure will get worse as this workforce has an older age profile – meaning that significant numbers are approaching retirement.

- There is a shortage of GPs. By 2021 the country will need 16,000 more GPs than there are now. Tower Hamlets and Newham already have some of the worst GP to patient ratios in the country (CfWI, 2012). It is an ageing workforce. In London 17% of GPs are over 60 compared to 10% nationally, and many areas are dependent on single-handed GP practices.

- There are key clinical skills / training gaps. Only 31% of the capital’s GPs believe they have received sufficient training to diagnose and manage dementia\(^1\) 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\(^2\).

- The wider primary care workforce is not utilised effectively. A north central and east London primary care workforce project, working with the Local Education and Training Board found that some key ways to address this would mean a greater focus on:
  - team working across professional boundaries
  - fostering innovation through education
  - developing new roles in navigation skills and support
  - the development of practice nurses
  - improving healthcare support workers training
  - community pharmacy development.

\(^1\)NHS England \(^2\)Child Health and Maternity Partnership
Our workforce does not support new models of care

*London Quality Standards*

- Clinical experts and patient panels have developed evidence-based quality standards for each service area. Compliance with the London Quality Standards is not mandatory, but assessment against them does illustrate some key workforce issues.
- The London Quality Standards have been an important mechanism in establishing a move towards seven day working and significant changes to working patterns around how emergency and planned care clinical responsibilities are managed.
- Self-assessments at Barts Health and Homerton show there are a number of London Quality Standards that are unmet both on weekdays and at weekends.

![Barts Health self-assessment (2013)](image)

- Standards not met = 304, 30%
- Standards met = 698, 70%
- Orthopedics have the highest number of unmet standards
- Acute medicine at Whipps Cross and critical care at Newham had a higher number of unmet standards out of hours than other services

![Homerton self-assessment (2013)](image)

- Standards not met = 86, 25%
- Standards met = 256, 75%
- The area with the highest number of unmet standards was Adult General Emergency Surgery
- Of those standards that were not met, 42 were unmet at weekends and 44 were unmet during weekdays
We will require new roles, new skills and new training

The *named clinician* ambition in primary care will be a challenge

- The Department of Health is consulting on its proposal for a named clinician: providing a single point of contact to coordinate the care of vulnerable older people. This policy is likely to have a significant resource impact for General Practice and will mean thinking differently about how we develop the rest of the workforce (practice nurses, healthcare assistants and community teams).

Current skill mix and training is not necessarily appropriate

- We need a greater focus on education and training of staff – both formal (e.g. courses) and informal (e.g. staff rotations)
- Future models of care suggest a need to change the skill mix of the workforce. This is driven by:
  - increased delivery of care in a community setting
  - integrated care
  - the introduction of seven day services.

For example, the Academy of Royal Colleges has suggested that there is a need for a more generalist consultant physician role that can undertake ward rounds and agree patient discharges at weekends and out of hours. This may impact on how we train healthcare staff and the commissioning of education. This will be particularly important to the delivery of integrated care, creating roles that can cut across professional and organisational boundaries

- Increased flexibility will also be a key skill of the future clinical workforce. We are likely to see clinicians travelling to deliver care in a community setting or providing alternatives to face to face care for patients, enabled by technological development.
Our workforce needs to be better engaged and motivated

- An engaged and motivated workforce is essential. Trusts with higher levels of staff engagement are generally rated by the Care Quality Commission as outperforming other trusts. They have:
  - better quality services
  - more robust finances
  - higher patient satisfaction scores
  - lower staff absenteeism
  - consistently lower patient mortality rates
- The CQC stated (Jan 2014) that staff feel disconnected from Barts Health’s executive leadership team, undervalued and unsupported. They reported that morale was low across all staffing levels and some staff felt bullied. In their 2013 NHS Staff Survey, Barts Health received scores in the lowest 20% nationally for overall staff engagement and staff recommending the trust as a place to work or to received treatment. However staff do believe their role makes a difference to patients

Barts Health measures staff engagement within the organisation. The results in March 2014 showed significant variance across Clinical Academic Groups (CAG), with engagement ranging from 56% of staff in women’s health to 33% in clinical support services

Women’s and children’s CAG has identified issues relating to culture and behaviour. There is a programme underway, Great Expectations, which addresses the levels of bullying and harassment that staff in this CAG are reporting (47%).

In primary care, Newham CCG have reported challenges in attracting and retaining GPs, nurses and practice managers.
5. Do we use our resources in a sustainable way?
Our resources: Summary

The NHS and local government are facing significant real terms reductions in funding. We need to work together to make better use of our resources so that we can improve patient experiences, and invest in better care. In particular we need to:

i) make more than £400m of **quality and productivity savings** over the next five years and get better at **preventing ill health** if we are to become financially sustainable.

ii) **improve communication and information sharing** across different parts of the NHS and with our partners so patients can better care for themselves and do not have unnecessary appointments and tests

iii) make **more effective use of technology** to improve care and make savings

iv) make **better use of estates**

v) make **choices about the best way to spend resources**, for instance reducing the amount of money we spend on buildings and support services
Case studies: We have invested in some excellent facilities and we are improving services whilst making savings

- Barts Health has saved over £2 million in the last few years by cutting water consumption, recycling more and saving energy (a scheme which is set to save £400,000 a year and won the HSJ Energy Efficiencies Award)
- Homerton Hospital has saved money by retendering services, reducing reliance on agency staff and increasing productivity in theatres.

- A new acute assessment unit has recently opened at Whipps Cross as part of a £27m investment in emergency care at the hospital
- Patients are benefiting from a £7m redevelopment of the A&E at Newham and £17.5m investment in the maternity unit
- A new Royal London hospital. A world class specialist cardiovascular centre at St Bartholomew’s has the potential to save up to a 1,000 lives a year
- The Sir Ludwig Guttmann Health Centre in the Olympic Park will provide state of the art primary and community health facilities for the growing local population
- A £4m scheme at Homerton to refurbish the Clifden centre for sexual health and open the Jonathan Mann clinic for the treatment and support of people with HIV.
NHS funding to commission health services is reducing in real terms

- NHS England commission primary care services (GPs, pharmacists, dentists, optometrists)
- CCGs commission community, mental health and acute hospital care services
- NHS England commission specialised services (e.g. trauma, neurosurgery). About a third of services provided by Barts Health are specialised.

National efficiency requirement of 2.5%, and current allocation method is under review. Co-commissioning with CCGs is being considered. Current expenditure on GP contracts for Tower Hamlets, Newham and Waltham Forest is £118m (incl associated costs). Primary care spend in East London is in lowest 25% nationally.

CCG funding varies from £1,555 per head in Tower Hamlets to £970 per head in Waltham Forest (2014/15). This will reduce in real terms over the next five years by an average of 11% across the three CCGs, meaning the CCGs need to make £128m of savings. WF CCG has the lowest funding per head and is currently in deficit.

NHS England is looking at least 3% efficiency savings each year, and there is a long term affordability challenge as demand historically grows by 5% each year, and as widely reported a balanced budget for 14/15 was only achieved nationally through non-recurrent support.
NHS providers are facing significant financial challenges

- Local hospital, community and mental health providers are all facing significant financial challenges as funding is held steady and is not keeping pace with inflation, pay increases or other cost pressures. Providers are also facing reductions in funding as a result of new models of primary and community care and commissioner savings plans.
- Projecting future income and costs forward shows that local providers will need to find £434m of savings over the next five years:
  - Barts Health: £324m of savings. (5.1% of turnover)
  - Homerton: £54m of savings. (3.8% of turnover)
  - East London Foundation Trust: £56m. (3.9% of turnover)
- Barts Health in particular has a big challenge with an underlying deficit of £47m in 2014-15.
- These challenges predate the Barts Health merger and provided some of the rationale for the merger, however only a small proportion of the expected savings have been delivered to date.
We need to work together to find ways to deliver better value

- The productivity of Barts Health when compared to similar organisations shows there are opportunities for making efficiencies.
- Of the £324m of savings required, it is estimated that approximately £200m could be achieved through productivity improvements and a further £38m through better recovery of income (although this will then present a cost pressure for commissioners). Examples of productivity improvements include:
  - reducing length of stay
  - reducing costs of clinical supplies
  - standardising best practice pathways
  - making better use of the staff we have
  - better methods of measuring performance, leading to local improvements
  - improving asset utilisation
- Productivity gains will require new ways of working and this will require contributions from all partners in the health economy.
- Better productivity will not achieve all the savings required so there will be a need to make savings from other initiatives such as reconfiguration of services and rationalisation of estates.
We need to improve basic information sharing and communications

Better communications and sharing of information can save money, provide better care and an improved patient experience

- The NHS often communicates via paper (referral letters, requests for tests and tests results), even for urgent cases
- Patients are still expected to book consultations on the phone or in person (creating extra work and delays), and attend consultations in person (generating a reliance on the physical estate). We do not make best use of mobile technology; texting and emailing
- Our IT systems are not designed to support mobile management or remote care.

We do not share information consistently or effectively

Patients are often seen by many staff, who are working across many systems. Tests are duplicated and patients are asked for information many times. Patients have a right to expect that a single summary record should be able to be shared between the NHS to ensure a joined-up service.

This is a challenge as:

1. The NHS has many different information systems and platforms
2. These systems do not easily interact with one another
3. Inconsistent levels of information are recorded and shared

We need to increase the use of NHS numbers to enable records to be linked and shared.
There are opportunities to better harness technology

There are great opportunities for technology to change the way we work. Technology can help save money, provide better care and an improved patient experience, treat people in rural areas or who are less mobile, and train doctors…

We need to consider:

• A surgeon at The Royal London Hospital has become the first in the UK to broadcast online a live surgical procedure using a pair of Google Glasses. 13,000 students watched live from 115 countries on a computer or mobile phone, and had the opportunity to put their questions directly to the surgeon

• The first person in the UK was fitted with a wireless pacemaker at Barts last year

• Wireless fetal monitoring equipment is being used at Newham allowing women with higher risk deliveries to still have the choice of a water birth.

• A team at Johns Hopkins University uses videoconferencing to provide speech therapy to patients suffering with a cleft palate in other countries

• The use of self-monitoring devices to empower patients in their self-care. For instance, Myhealthlocker is electronic personal health record for people using mental health services. Service users can collect, store, edit and manage their own health information, including their GP and hospital records, in one place. Rate my day is an online tool to track sleep, anxiety and energy levels
We are too reliant on estates and facilities that we do not use effectively

Because the way we work is based on physical and paper interactions, we spend a lot of our shrinking financial envelope on estate that we don’t use effectively. *Every £ spent on inefficient estate is a £ that could be spent on improving care*

**Quality of the community & primary care estate:** There are nearly 150 GP practices and approximately 70 community premises in inner north east London (Waltham Forest, Newham and Tower Hamlets) costing an estimated £90m per year. Some of these facilities are poor and not fit for providing modern healthcare delivery. Extended work hours and new technologies could support a reduction in the number of premises that we need; and bringing services together into fewer, larger premises could help us deliver better care and reduce costs.

**Full utilisation of the best quality estate:** A large part of the estate is new (or newly reconditioned). The challenge for much of this new estate is to make sure that it is fully utilised. For example much of the Sir Ludwig Guttmann Health Centre in the Olympic Park is currently empty, although it will become a valuable resource as the population in the area grows. There is also space that could be better utilised at the Royal London, Newham Hospital and a number of health centres.

**Whipps Cross:** The most significant estates issue in secondary care is the Whipps Cross site. Much of the site is more than a century old, in a poor state of repair and not suitable as a place for providing healthcare in the 21st century. Barts Health Trust and the CCGs all agree that this is not acceptable and that the redevelopment or modernisation of the site is essential. Future plans for Whipps Cross need to be founded on a strong clinical strategy for East London.
6. What change is needed?

Next steps and priorities
Based on our findings, the key areas for change for our local NHS services are emerging as …

- **Ensure local services meet local needs**
  - Use technology as an enabler for information sharing and innovative care
  - Make the best use of the estate
  - Make the best use of the NHS budget (and address financial challenge)
- **Transforming Services, Changing Lives**
  - Recognise patients as experts in own health and care and to engage in the self-management of their condition
  - Harness technology to improve outcomes and deliver best value
  - Engage, support and develop staff
- **Develop a clear shared vision with strong clinical leadership**
  - Work closely with local authority partners and Health and Well Being Boards
  - Engage local communities in designing care and communicate clearly
  - Develop a shared vision of what good looks like and how to get there
  - Recognise the critical importance of excellent patient experience
  - Use data to develop improvement plans to drive change across boundaries, including 24/7 working
  - Develop a shared vision of what good looks like and how to get there
- **Engage staff and support them to drive improvements in care**
  - Workforce redesign and training to meet changing needs
  - Address pressing workforce gaps to ensure standards can be met
  - Engage staff and support them to drive improvements in care
Realising this requires change system-wide change…

- A clear **understanding of any changes in demand** for healthcare services and plans in place to be able to respond

- A single **shared vision** across the healthcare economy, created jointly by clinicians, and patients to deliver the best outcomes for patients and deliver continuous improvement – this will require **choices** to be made about how and where the budget should be spent

- Supporting **self-care for patients** so that people are empowered to take responsibility for protecting and promoting their own health, keeping their appointments and using their NHS services appropriately

- **Strong primary healthcare** services, where GPs and their teams are supported by the broader healthcare system to coordinate care on behalf of their patients

- A system which **promotes mental and physical health together**, and develops services based around the holistic needs of patients

- **Changes to the way that hospital services** are delivered to make the best use of resources and **ensure consistent high quality care** is available for all local residents, **365 days per year and 24 hours per day when needed**.

- Supporting **collaborative and coordinated working** across the system by providers, clinicians and commissioners for the benefit of patients

- A system which **supports and nurtures innovation** and removes the current barriers to improving care
Together we can achieve…

Great health and health outcomes for people in East London, such as:

- People supported to manage their long term condition in the community
- More people surviving life threatening events such as stroke, heart attack or major trauma
- People supported to die at home where it is their choice to do so
- Patients reporting improvements in their quality of life as a result of health care interventions
- Patients reporting an excellent experience when accessing healthcare
To know more
If you would like to discuss any elements of this draft case for change, please contact our team on:
Tel: 020 3688 1678
Email: tscl@nelcsu.nhs.uk
www.transformingservices.org.uk
The Case for Change in our specific clinical areas

In order to develop the *Case for Change*, we formed six Clinical Working Groups, focused on:

- Maternity and newborn care
- Children and young people
- Planned care: long term conditions
- Unplanned Care
- Planned care: elective surgery
- Clinical support services

Each of these clinical working groups has been developing specific cases for changes. These are contained in the interim clinical working group reports. The interim reports will be further enhanced over coming months, particularly looking at the cross cutting themes between groups.

The following slides summarise the specific changes that have been developed by the clinical working groups.
Maternity and Newborn Care

**Introduction**

The birth rate in England has been rising between 2001 and 2012 with a 23% increase in babies born between 2001 and 2012 and reaching 694,241 births in 2012, its highest number since 1971. East London has amongst the highest birth rates in England with the biggest growth in Newham, Redbridge, Barking and Dagenham, and Waltham Forest. Linear projection indicates that there could be 5,800 additional births by 2020 (though Greater London Authority forecasts are 1,795 – 1,968). It is a constant challenge to ensure maternity and newborn care services can continue to respond to this population growth.

Our population is culturally diverse, with over 50% of the population in the inner north east London boroughs belonging to black and minority ethnic communities. We need health services to address access issues (language and understanding of healthcare navigation) and cultural and physiological differences. For example women of South Asian descent have a higher stillbirth rate compared to white British women.

The complexity and acuity of pregnancy is increasing nationally, linked to women with high BMIs and pre-existing medical conditions. For example prevalence of diabetes in Newham is almost four times the London average. This is putting increased demand on maternity services where more women are requiring interventions beyond the standard pathway.

Parts of East London have higher than national average rates of population mobility with a population turnover of around 30% in Newham. As a result of this, having robust safeguarding processes and procedures in place is of central importance. GP registration rates are low and early education, identification and intervention for pregnant women is challenging. Newham, Waltham Forest and City and Hackney all exhibit low rates of antenatal assessments by 13 weeks compared to the national average.

East London exhibits high rates of low birth weight babies at full term compared to the England average with 9.2% (WF), 10.2% (TH), 10.1% (Newham) and 10.2% (C&H) of live and stillbirths weighing less than 2,500g. Where these babies transition into paediatric care, the quality of this transition is of central important.

Perinatal mortality rates (measured as all still births and deaths before seven days per 1,000 births for three years 2010-2012) are high in East London boroughs, with rates of 9.7 (Tower Hamlets), 8.5 (Newham) and 7.8 (Waltham Forest) against an England average of 7.3 and a London average of 7.8.

Rates of poverty and family homelessness are worse than the England average, contributing to poor nutrition and increased likelihood of complications during pregnancy. This puts more importance on antenatal and intrapartum care. Mental health prevalence in North East London is higher than the England average requiring close attention of women during antenatal and postnatal care.

Acute and community maternity services have achieved success with breastfeeding rates (for women breastfeeding in the first 48 hours and at 6-8 weeks) and similar success with reducing the percentage of women smoking at time of delivery (amongst the best performers nationally).
Maternity and Newborn Care

What does good look like?

Standardised pathways with smooth transitions delivered by a supportive, empathetic workforce

PRINCIPLE 1
Antenatal care provided close to home

Antenatal care should start early and be integrated with local authorities and support groups. Women with lower risk pregnancies should receive their antenatal care close to home with continuity of care from a named and known midwife.

PRINCIPLE 2
High quality intrapartum care

All women should receive consistent, high quality care during labour, regardless of the place of birth, team providing the care, time of day or day of the week. Women should have informed choice of where they want to deliver their baby and midwife-led deliveries should be seen as the norm for low risk pregnancies.

PRINCIPLE 3
High quality postnatal care

Women and their newborn babies should receive consistent, high quality postnatal care regardless of where they live and where their baby is delivered. Women should be offered the same named and known midwife as their antenatal care, which should be joined up across different providers with ‘normal care’ close to home.

PRINCIPLE 4
Newborn care close to home where appropriate and specialist centres where needed

Every baby should receive appropriate high quality care, close to home where possible and at specialist centres where appropriate. Babies with specialist needs should be identified early, with their deliveries at specialist centres. This should be supported by robust clinical networks with standardised pathways and protocols.

Underpinned by preventative approaches, robust approaches to safeguarding and continuity of care

Parity of esteem for mental and physical health
Early identification, early intervention
Joined up across different services and teams
A patient centred approach
Consistent care across the geography
Care close to home
Supported staff

What is working well at the moment?

• Royal London first NHS trust in London to receive UNICEF’s baby friendly accreditation for implementing recommended standards to promote and sustain breastfeeding in both hospital and community settings. Breastfeeding rates across the boroughs are good compared to national averages
• There has been a reduction in rates of caesarean section births at Newham from 30.8% in 2012/13 to 27.0% in 2013/14 with a focus on the induction pathway
• One-stop maternity clinics have been introduced at The Royal London, allowing women to complete their history, booking, blood test and 12 week scan in a single appointment
• The Family Nurse Partnership programme has proved successful in reaching out to first time young mothers and fathers and highlights success working with voluntary organisations
• Homerton’s public health midwives and support groups are achieving success in reaching women from ethnic minorities that were previously booking late
• Clinicians have reported a good patient experience at the two stand alone midwife-led birthing centres (Barking and Barkantine centres)
• Perinatal mental health services for pre-existing mental health conditions are good on all sites
• Joined up postnatal care in Hackney is aided by clear pathways and good communication
• Use of techniques such as fetal fibronectin and transvaginal cervical scans at Whips Cross to identify women in labour and interventional radiology at the Royal London
• Newham is top in London for flu immunization rates in pregnant women with an uptake of 56%, significantly higher than the London average uptake of 35.9%
• East London Foundation Trust have a family-centred specialist Mother and Baby Unit caring for mothers who experience severe mental health difficulties during and after pregnancy
# Maternity and Newborn Care

## What is not working well?

### PRINCIPLE 1
**Antenatal care**
- The quality and experience of antenatal care is inconsistent due to a lack of standard and visible pathways across the CCGs. Barts Health was amongst the worst performing trusts nationally for antenatal care in the 2013 National Maternity Services Survey.
- Too many women with low risk pregnancies are having to travel to acute sites for their antenatal care when they could have received high quality care closer to home.
- Too many women are not starting their antenatal care early enough meaning that risks are not being identified and managed. Across our CCGs we are seeing significant variation from 63.9% pregnant women having their first antenatal assessment by 13 weeks in one borough to 96.1% in another, against a national average of 86.2%.
- Too few women have a named and known midwife through their antenatal and postnatal care and there are inconsistencies in monitoring this standard.

### PRINCIPLE 2
**Intrapartum Care**
- Delivery units are reaching and exceeding capacity limits defined by Royal College standards for safe care.
- Managing demand and capacity is a constant challenge. There are more obstetric deliveries than clinically necessary and freestanding midwife-led units are underutilised. 6.2% of Barts deliveries were in freestanding midwife-led units or home births in 2012/13 against a recommendation of 10% from Health for North East London.
- There are high variances in the caesarean section and intervention rates across sites suggesting variances in pathways and protocols. Caesarean section rates vary from 27.0% to 29.5% of births across our sites and intervention rates vary from 4.7% to 13.7%.

### PRINCIPLE 3
**Postnatal care**
- Women and their babies in NEL do not have equal access to consistently high quality postnatal care resulting from a lack of standardised pathways.
- Communication between different services is inconsistent and members of the CWG are seeing too many women and babies where problems are not being identified and treated early enough. Responsibilities across different service providers is often unclear, particularly for out of area births.
- ‘Insufficient maternity staff for aftercare and discharge’ was ranked as one of the top 10 patient concerns in the Tower Hamlets Healthwatch survey of 2013.

### PRINCIPLE 4
**Newborn Care**
- Perinatal mortality rates in all east London boroughs are some of the worst in England.
- Neonatal care activity is changing and capacity management is becoming increasingly difficult. Intensive care cot activity across Barts and Homerton has risen by 11% (2011-12-2013/14). High dependency activity has increased by 1.5% and special care activity has fallen by 8%. There are challenges with ensuring appropriate staffing levels to respond to these trends.
- Rates of 1:1 nursing for intensive care varies across units and suggests variance in the ability to meet British Association of Perinatal Medicine staffing standards and ultimately quality of care.
- Without a standardised pathway for transitional neonatal care there is variance in care across sites resulting in variations in practice, delayed discharges, increased pressure on neonatal unit capacity, and a poorer family experience.
- The transitions to paediatric services are not adequately supported by efficient and effective handovers.

## What are the constraints?

- There is not sufficient flex within existing birthing units to accommodate the forecast extra births and patient choice.
- There is a national shortage of qualified midwives (particularly hospital midwives in London) and consultant obstetricians to deliver minimum standards. This is particularly affecting postnatal care where midwives are pulled into delivering intrapartum care.
- East London has high and rising rates of complex pregnancies contributing to high rates of low birth weight babies.
- High rates of ethnic minorities and a transient population mean that early booking and monitoring of pregnancies is more difficult.
- IT technology is not properly joined up across the acute and community setting or across CCG geographies making communication and access to relevant information more difficult.
- Commissioning arrangements (National tariff, GMS and PMS contracts) do not incentivise consistency across CCGs or managing women along the normal pathway with good postnatal and antenatal care close to home.
- Services are limited by the quality of local of estates. Continuity of care is more difficult to achieve where patients are having births out of area
- Limited transport links make it difficult to utilise managed flow of deliveries whilst achieving good patient experience

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“We are seeing too much variance and too little communication across teams and organisations resulting in inconsistent care for our population” – Dr Elizabeth Goodyear, Co-chair
Introduction

The Children and Young People Clinical Working Group consists of 13 members from a range of commissioners and providers and from different clinical disciplines including hospital doctors, nurses, GPs and a clinical psychiatrist. The remit of the Children and Young People’s Clinical Working Group has been to look at the full range of clinical services provided to children and young people in hospital services, including unplanned care, surgery and services for children with long term conditions, as well as the broader healthcare system that influences how these are provided.

East London has a relatively young population with approximately 217,000 children or 27% of the population aged 0-19. In line with overall projected population growth rates for Newham, Tower Hamlets and Waltham Forest, the number of children and young people within the three CCGs continue to rise rapidly with approximately 8% growth expected over the next five years (representing an additional 16,000 children and young people). Growth is particularly high in the 10-14 age group. The local population changes rapidly, which results in a need for robust safeguarding procedures and approaches.

The population of children and young people is culturally diverse, with between 80.2% (Waltham Forest) and 92.8% (Newham) of school children from a minority ethnic group.

East London performs poorly against a number of key public health indicators for children and young people:

- **Child poverty and poor nutrition** rates are high in East London and contribute to higher demands on health services. The rate of child poverty and family homelessness is worse than the England average with between 23% (Redbridge) and 43.6% (Tower Hamlets) of children under 16 years living in poverty against an England average of 20.6%

- Children have worse than average levels of obesity ranging from 10% to 12.8% in 4-5 year olds compared to an English average of 9.3% and 21.5% and 27.5% for children aged 10-11 years compared to an English average of 18.9%

- When looking at average performance across East London, the area is in the bottom national quartile of **immunisation of children**, although good practice is noted in Tower Hamlets

- East London boroughs all exhibit higher rates of **low birth weight babies** (under 2.5kg) compared to the English average with 9.1% (Redbridge) and 10.2% in Newham, which is an indicator of poorer child health and associated complications.

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<td>Obese children (4-5 years)</td>
<td>% reception pupils</td>
<td>12.3</td>
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<td>Obese children (10-11 years)</td>
<td>% year six pupils</td>
<td>27.5</td>
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<td>22.6</td>
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<td>Children with one or more decayed, missing or filled teeth</td>
<td>% children aged five years</td>
<td>39.0</td>
<td>45.9</td>
<td>26.5</td>
<td>27.9</td>
<td>53.2</td>
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* Red = Significantly worse than national average
Yellow = Not significantly different
Green = Significantly better than national average
1. Seamless transitions of care
Young people should be well supported into adult services and should receive individualised care in environments that are appropriate for their age.

2. Integration of community care:
Children and young people should receive coordinated care across teams within and between acute, community and primary care. Care should be provided with as few contacts as possible and close to home or education settings where possible.

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

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

What is working well?
- An innovative pilot project in Tower Hamlets has developed a virtual ward for children with complex needs.
- The Children’s Hospital at Barts Health offers a wide range of regionally recognised specialised medical and surgical services including paediatric intensive care within close reach to the children of East London.
- The liaison health visitor service at Whips Cross is a good safeguarding initiative.
- The Newham Paediatric Clinical Decision Unit which operates in A&E provides important observation facilities and is contributing to reduced admissions.
- The Homerton’s integrated ambulatory model incorporates rapid access to consultants, short stay observation and assessment and care at home from a seven day community children nursing team. The model is proving successful at reducing length of stay, reducing attendance at the Children’s Emergency Assessment unit and readmissions.
- The ‘best start in life’ pilot project in Waltham Forest is a monthly integrated care style meeting of GPs, Midwives, Children’s Centres, Heath Visitors and early intervention and prevention teams for children 0-5 years. Outcomes are currently being evaluated by Public Health.
- The integrated Children’s Division at the Homerton has facilitated the development of multi-disciplinary pathways across neonatal, general and community services. Examples include pre-term infant follow up, continence and epilepsy.
- The short stay A&E model operating at the Royal London.
- An advice hotline and email service for GPs in Tower Hamlets is receiving positive feedback from GPs with similar schemes at Newham and Whipp’s Cross being evaluated.
- Childhood vaccination uptake in Tower Hamlets is higher than the England average for MMR (93.8%) and Dtap / IPV / Hib (97.3%) which is outstanding given the complexity of the population.
What is not working well?

1. Transitions of care
   - Clinicians are seeing too many young adults struggle to adapt to adult services and their health outcomes are suffering as a consequence
   - Young people’s transition to adult services is elongated and complex with different services setting different ages for transition, from 16 years for inpatient care, 18 for mental health, 19 for safeguarding and 25 for Special Educational Needs
   - We lack safety mechanisms to ensure that young people transitioning to adult services do not fall out of care. This is a particular risk for people transitioning with long term conditions
   - Young people (adolescents) are being cared for in environments, including hospital wards, that are not appropriate to their age.

2. Integration of community care
   - Children and young people with complex needs are given lots of appointments with a large number of teams to deal with a set of issues, with little coordination
   - Children and young people are not having mental health conditions identified and effectively managed quickly enough. Emergency hospital admission rates with a self-harm diagnosis have risen by 13% between 2007/08 and 2013/14 across the CCGs
   - Children and young people are inconvenienced by appointments at acute outpatients, far away from their school and home
   - Community paediatric services are inconsistent across CCGs and often lack specialist skills and knowledge.

3. Hospital care pathways
   - We do not have effective care networks for specialist care, medical care, elective surgery and emergency surgery, as recommended by Health for NEL
   - With a lack of visible, standardised pathways and protocols CWG members can not be confident that all children and young people are given equal access to care
   - There is variance in the models of care for children and young people in hospital. Whips Cross is the only site where all emergency admissions are seen and assessed by the responsible consultant within 12 hours of admission and paediatric surgical and anaesthetic expertise is not provided across all sites.
   - In diabetes care patients’ experiences are variable across sites. Between 49.2% and 57.1% of children and young people (and their carers) managed at our sites felt they received enough information and knowledge to manage high blood glucose. This compares to a London average of 60.9%.

4. Urgent care
   - Too many children and young people appear to be attending A&E when they could be safely cared for at, or close to home. Between October 2012 and September 2013 73,555 attendances resulted in no treatment or treatment that could have been provided closer to home
   - A&E consultant staffing is not sufficient to provide consistent high quality care at all sites, 24 hours a day and seven days a week. A&E attendances for 0-19 year olds account for 28% of total A&E attendances at the Royal London yet only two of 24 A&E consultants are specialist paediatricians
   - There is high variance in non-elective admission rates across CCGs and sites. From 47 per 1,000 population to 64 per 1,000 in different CCG populations.
   - A&E observation facilities are inconsistent across A&E sites with limited facilities at Whips Cross and Newham.
   - Prevention and self care approaches, such as pharmacy first, are inconsistent and navigation can be difficult for patients and clinicians.

What are the constraints?

- Workforce:
  - Insufficient numbers of acute staff with the right skills and expertise to cope with current (and future) demands whilst complying with the European Working Time Directive
  - Insufficient community and primary care paediatric training to accommodate a shift in activity – nationally more than 50% of GPs do not have formal training in paediatrics and the local picture is unclear with a noticeable lack of training posts
  - The trend for specialisation of training is leading to a narrow focus for clinicians and has resulted in clinicians not giving enough consideration to the whole patient, including mental health
  - High rates of locum/agency staff and the doctors training system results in clinicians lacking knowledge of local services.
- Communication across different teams and services in primary, community and secondary care settings is limited by IT systems and knowledge of services
- Visibility and understanding of services is inconsistent, making it difficult for clinicians and patients to navigate services and provide equal access for all
- GP appointments are limited – short appointments with lack of time to observe child behaviour, insufficient access to additional clinical advice and second opinion
- Services are limited by the estates. Limited number, location and standard of estates. Difficult to access existing estates in community settings e.g. schools
- Commissioning arrangements do not incentivise joint working and can create perverse incentives to optimal patient care - block contracts, Payment by Results systems, multiple commissioners and multiple providers
- The WELC Integrated care programme does not currently include integrated care for children and young people
- We are not very effective at capturing the views of children and young people with appropriate methods and language and therefore design services for children and young people as opposed to designing services with them
- Parents and clinicians are more risk averse with the decision making than with adults and it can be difficult to be objective
Planned Care: Long Term Conditions (LTCs)

Introduction

The role of the Planned Care: Long Term Conditions Clinical Working Group has been to look at what good long term condition care looks like, how current services match up to this future vision and what the constraints or challenges are to achieving this vision. Chronic conditions are now the most common cause of death and disability in England (King’s Fund, 2013). There are over 15 million people in England living with long term conditions, equivalent to just under a third of the population. Whilst the number of people with one long term condition in England is projected to be relatively stable over the next 10 years, the number of people with multiple long term conditions is projected to rise by 2.9 million in 2018, from 1.9 million in 2008 (Department of Health, 2012).

The prevalence of some long-term conditions rises with age (except asthma for example), affecting about 50% of people aged 50, and 80% of those aged 65. Locally, the population is projected to grow at a rate that is twice as fast as the national average and the average age of the population is getting older. Over the next 20 years, the population of over 65s will increase by 37,000 (60%) and form 9% of the population (GLA projections). The impact that this has on the growth of the number of people living with long term conditions varies. For some conditions, we are not predicting a rise in prevalence, although, for some, such as diabetes, the rates in East London are growing at a rate faster than the national average. In Newham the prevalence of diabetes will be 56.8% higher than the national average in 2030.

Deprivation has also been found to influence the prevalence and severity of long term conditions, although this varies significantly by condition. High levels of deprivation are linked with poor underlying health and lower life expectancy, higher prevalence of mental health conditions and greater need for social care support. Deprivation has also been found to influence the prevalence and severity of long term conditions, although this varies significantly by condition. High levels of deprivation are linked with poor underlying health and lower life expectancy, higher prevalence of mental health conditions and greater need for social care support.

Locally, we have some of the highest levels of deprivation in England. For example, Hackney, Newham and Tower Hamlets are in the 10 most deprived local authorities in the country. Combined with Waltham Forest these boroughs have two times more deprivation than the national average.

Lifestyle factors, such as diet, lack of exercise, alcohol consumption and smoking, contribute to the prevalence of long term conditions. Smoking prevalence varies from 16.5% in Redbridge to 25.2% in Hackney. Although the average smoking prevalence across the inner north east London CCGs is 21.1% compared to a national average of 20.1%.

There are high levels of alcohol and substance abuse in the population. This is associated with high levels of secondary care use and significant cost to the health and social care system. For example, in the inner north east London boroughs the number of hospital stays for alcohol-related harm is significantly worse than the England average and there has been a 50% increase in the number of hospital stays for alcohol-related harm per 100,000 population since 2009.

In England, the prevalence of obesity among adults rose from 15% to 25% between 1993 and 2012. The rate of increase has slowed down since 2001, although the trend is still upwards. The prevalence of obesity in Newham, City and Hackney and Barking and Dagenham is also significantly worse than each borough’s ten comparator CCGs. If current trends in obesity continue the prevalence in WELC will increase by 40% over the next 20 years, just below 14% of the population in Newham.

People with long term conditions tend to be heavy users of health care resources. For example, they account for 50% of all GP appointments and 50% of all inpatient bed days. In the inner north east London boroughs, 20% of the population accounts for 80% of acute care costs.

Snap shot of the WELC Integrated Care Programme

Who? In September 2012, Newham, Tower Hamlets and Waltham Forest CCGs joined local councils, Barts Health, North East London Foundation Trust, East London Foundation Trust and UCL Partners to build an integrated care system across the three boroughs.

What? The programme aims to co-ordinate care around each patient and deliver it in the most appropriate setting. At the moment, the programme targets very high risk, high risk and moderate risk patients – those with long-term conditions, the elderly and people with mental health problems. The intention is to build a model of care that takes into account the person as a whole by 2017/18. It is, however, important to note that the programme does not address the needs of children.

How? The programme provides nine key interventions focused on self-care, care coordination and ensuring the patient is in the most appropriate setting of care. These are underpinned by five key components: information sharing; evidence-based pathways and care packages; joint health and social care assessment; creation of new roles; and organisations of practices. There are five key enablers (patient engagement; joint decision-making and accountability; clinical leadership and culture development; information sharing and decision support; and aligned incentives and reimbursement models).

Early outcomes?

- Using best practice care packages, Tower Hamlets has seen a 30% increase in immunisations in four years, and the proportion of diabetes patients with low blood pressure and low cholesterol is higher than the London averages.
- Newham has seen a 20% reduction in emergency admissions and 14% reduction in elective admissions by using telecare monitoring.
- Waltham Forest Integrated Case Management expects to see savings of £1m from fewer unplanned admissions in 2012/13.
### What does good look like?

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<tr>
<th>PRINCIPLE 1</th>
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<tr>
<td><strong>A high quality, interdisciplinary coordinated care approach is the norm for everyone with long term conditions</strong></td>
<td><strong>People are supported to live healthy lifestyles and empowered to take an active role in their care by supportive professionals</strong></td>
<td><strong>Primary Care-based teams proactively coordinate care for patients with long term conditions pulling in specialist expertise when necessary</strong></td>
<td><strong>Specialist support to deliver a model of long term condition care at, or as close to home as possible</strong></td>
<td><strong>Long term condition care addresses the mental and physical health care goals of individuals</strong></td>
<td><strong>People in the last years of life are supported to transition into palliative care</strong></td>
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- **High quality conversations and interactions that support the effective coordination of care across health and social care**
- **Supported by a shared care plan that is actively monitored and underpinned by collaborative relationships that transcend organisational and professional boundaries**
- **Patients are supported to play a proactive part in the management of their condition**
- **Carers are actively involved and supported in the interdisciplinary care approach**

- **Patients with LTCs are supported to make decisions and adopt healthier lifestyles to improve their health**
- **Healthcare professionals use collaborative approaches to identify goals, needs and expectations of patients. This includes the use of interventions that support strategic behavioural change, deliver information and strategies for living with LTCs.**
- **These interventions are supported by training, education and practice that are aligned to system incentives**

- **Teams are able to pull in specialist expertise, skills and services when needed, but treat patients holistically at all times**
- **Each patient with a LTC has a “key worker” within this team who acts as the coordinator of care and point of contact**
- **For patients with multiple LTCs their GP is their key worker**
- **GPs and patients have ready access to specialist advice face-to-face, over the telephone, email or Skype**

- **People with LTCs are managed at or as close to home as possible**
- **Specialists act as a “medical link” for Primary Care**
- **Flexible outpatient care enabled by technology**
- **Where inpatient care is required, it takes place in specialist centres with appropriate MDT of staff, facilities and support services, Care is centralised where necessary**
- **High quality services are available seven days a week, 24 hours a day where necessary**

- **There is parity of esteem between mental and physical health services**
- **Mental and physical health services are integrated**
- **MDT working includes mental health representation**
- **Care planning and care coordination addresses the mental and physical needs of patients**
- **LTC care needs to address the health goals of people with long term mental illness, whose physical health is often quite poor**

There is a greater emphasis on the prevention of long term conditions and promoting healthy lifestyles underpins the care of those with LTCs

### What is working well at the moment?

- **Social prescribing** is being used effectively in Tower Hamlets to provide preventative care in partnership with the voluntary sector
- **Skype consultations** are being used in Newham to deliver consultations for diabetic patients
- **Diabetes care packages** in Tower Hamlets are highly effective – as is the “medical link” provided as part of that service
- **Barts Health provides email advice and guidance** to primary and community care clinicians
- **Good progress is being made with the integrated care programme in WELC**
- **There is some early work being done to integrate clinical systems across the area for example, in Tower Hamlets using ORION to enable health and social care clinicians to view clinical information regardless of care setting and in Newham community health services are starting to integrate EMIS Web with general practice**
- **The virtual ward** in Newham provides a model of care that works across organisational and professional boundaries
- **The IAPT service in Newham is working well. E.g. 59% of patients who complete treatment move into recovery. This is against a target of 50%. The London average is 41%**
- **Rheumatology self help group at Whipps Cross mixes self-care techniques with treatment. The service has good feedback from patients.**
- **The memory clinic run by the Alzheimer’s Society in Tower Hamlets and Newham is a good example of partnership with the voluntary sector. The service ongoing support to patients with low to moderate dementia needs.”**
# Planned care: Long Term Conditions

## What is not working well?

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<tr>
<th>PRINCIPLE 1</th>
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<tr>
<td><strong>High quality care planning is not systematically delivered</strong></td>
<td><strong>The current approach to supporting self-management is piecemeal and tokenistic</strong></td>
<td><strong>Primary Care teams are not set up to be the coordinator of care for patients with LTCs</strong></td>
<td><strong>The current model of outpatient care is outdated and there is variation in hospital care</strong></td>
<td><strong>There is opportunity to improve equality between physical and mental health</strong></td>
<td><strong>Too many people are not getting high quality care at the end of their life</strong></td>
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<td>• Over average 91% of patients responded “no” when asked whether they had a written care plan (GP Survey, 2014)</td>
<td>• CCGs in east London do not meet the national benchmark for people feeling supported to manage their condition (57.5% vs. 68.5%)</td>
<td>• There is variation in the level of care (quality and access) being provided to LTC patients across the patch</td>
<td>• This is compounded by contractual arrangements, custom and practice</td>
<td>• 75% of people say they would prefer to die at home (DH, 2013). Nationally, 21% of people die at home. Locally, only City and Hackney exceed this benchmark (22.52%).</td>
<td>• None of the CCGs in east London have lower than the national average rates (50%) for patients dying in hospital.</td>
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<tr>
<td>• Care planning is done in organisational silos</td>
<td>• There is a paternalistic and over-medicalised model of care</td>
<td>• GPs do not consistently have ready access to specialist expertise across the patch</td>
<td>• Three monthly routine interactions between the specialist and patient can only be 10 minutes long and may add limited value</td>
<td>• Waltham Forest has the lowest proportion of people dying at home (17%) and the highest proportion of people dying in hospital (67%)</td>
<td>• Care needs to be appropriate to the needs of the individual including supporting people to die with dignity.</td>
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<td>• Systems and technology are not set up to support collaborative care planning</td>
<td>• Professional training focuses on curative models of care rather than understanding strategic behavioural change</td>
<td>• There is a need to upskill the primary care workforce to feel confident to manage uncertainty</td>
<td>• There is large variation in emergency admissions for chronic ambulatory care sensitive conditions (from 250.9 emergency admissions in City and Hackney to 1205.9 in Barking and Dagenham. The national average is 795.1)</td>
<td>• Mental health problems are much more common in those with physical health problems. E.g. People with two or more long term conditions are seven times more likely to have depression.</td>
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<td>• Healthcare professionals lack the space and time to have high quality conversations to support effective care planning.</td>
<td>• Lack of engagement of patients in consultations e.g. 50% of medication prescribed for LTCs is not taken or not taken as prescribed</td>
<td>• There is insufficient promotion of the prevention of LTCs. Not enough patients with LTCs are supported to address unhealthy lifestyles.</td>
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## What are the constraints?

- **Perverse incentives** – current funding system is not set up to support the future model of long term condition care: there needs to be a win-win for all involved
- **Unsustainable workforce** – declining primary care workforce with fewer GP and primary care staff than is required for population size. There is a gap in the acute workforce in terms of generalist acute physicians
- **Outdated training and education** – training and education needs to reflect a more holistic model of care that involves an increasing emphasis on strategic behavioural change as well as curative clinical models
- **Increasingly specialised model of care** - which is exacerbated by the increasingly fragmented health and social care system
- The system needs to transform from one that is reactive to one that is proactive and is set up to promote collaborative, cross-site, cross-profession and cross-organisation working e.g. IT connectivity, separate forums for decision-making and separate budgets.
Planned Care: Elective Surgery

Introduction

The role of the Elective Surgery Clinical Working Group has been to look at planned, non-emergency surgical procedures that are either medically required (e.g. cataract surgery) or optional (e.g. breast augmentation). The nature of critical co-dependencies meant the group also considered the links to emergency surgery provision.

Data shows that there is a variation in elective surgical spells across WEL. This may in part be driven by differences in population health need, but may also indicate variations in clinical practice. This variation in access, delivery, performance and outcomes was a key area of focus for the CWG.

At the moment, we know that people are receiving variable standards of care and currently Referral to Treatment Times (the 18 week target) performance varies across the patch and across specialties – Barts Health underperformed with 82.55% (failing to achieve the 90% standard in nine specialties). The Homerton achieved the standard with 91.47%.

There is evidence to suggest that for some specialties, consolidation of services leads to improved efficiencies and outcomes. In other cases it may be better and possible to deliver services locally. Clinicians in the group feel that there is an opportunity to strengthen local surgical and clinical offerings, while achieving better outcomes by agreeing where and when specialised delivery would be more effective. However, any such changes must take into account the fact that surgery currently underpins any local delivery of A&E, maternity or paediatric services. The effect of these critical interdependencies needs to be fully understood and mitigated to ensure the provision of a functional local hospital based on population needs.
Planned Care: Elective Surgery

**What does good look like?**

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<tr>
<th>PRINCIPLE 1</th>
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<tbody>
<tr>
<td>Appropriate access to high quality surgery</td>
<td>Appropriate preoperative care closer to home</td>
<td>Separation of elective and emergency surgery</td>
<td>Day cases as the norm</td>
<td>Safe care, in the right place at the right time</td>
<td>Coordinated reablement and recovery</td>
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- There should be appropriate access to high quality safe elective surgery
- There should not be unwarranted variation in referrals
- Patients are making informed choices about their care
- High quality, supported clinical decision making.

- Enabling safer care, getting it right first time
- Delivered through improved links with primary and community care
- Reduction in preoperative bed days
- Robust surgical protocols and pathways in place
- Shorter pathways, streamlined process.

- Reducing the number of cancelled operations
- Improved outcomes and efficiencies
- Better use of theatre capacity and facilities
- Allowing surgeons to separate their commitments.

- Supporting people to return home after surgery as soon as it is safe for them
- Will deliver improved outcomes and efficiency
- Enhanced recovery can reduce number of bed days even for complex procedures
- Strong links to pre- and post operative parts of the pathway.

- Consolidation of services where this provides efficiencies and outcomes
- Improved local, high quality surgical provision where appropriate
- Performing normal operations at the highest possible standard and complex operations as safely as possible

- Getting people better and home quicker
- A reduction in bed days
- Continuity and extension of surgical care and integration with community and primary care

**Supported by:** Informed patient choice, a good understanding of capacity and demand, a skilled well developed and motivated workforce, integrated care pathways and latest developments in technology

**Underpinned by:** Shared clinical responsibly for the patient along the whole pathway

**What is working well at the moment?**

- The elective ophthalmology pathway provides a good template that could be adapted for conditions where specialist centres exist
- Hepato-Pancreato-Biliary surgery within Barts provides a good example of managing a tertiary service alongside a local one, and delivering high quality care for both
- The Newham Gateway Centre offers state of the art facilities that can be used to increase theatre capacity
- Homerton operates well as a smaller trust and has good internal hospital systems with a good focus on improvements and flexibility to ensure delivery of high quality care (e.g. separation of surgical and medical beds)
- Bariatric surgery at Homerton is a example of national provision of specialist services at a trust with no tertiary provision. The trust accounts for 10% of national bariatric surgery (over 500 cases a year). This is a good indicator of how, in East London, specialised services can be delivered in a healthcare setting in a way that supports a trust appropriately aligned to population health need
- Homerton provide a range of ‘straight to test’ pathways to shorten pathways, reduce unnecessary appointments and speed up the process for patients
- Homerton is an example of how it is possible to deliver local services successfully, achieving good outcomes and good family and friends tests. This is in part due to the beneficial interdependencies of the Royal London being nearby and taking some of the more complex patients
- For the majority of designated day case procedures (British Association of Day Case Surgeons basket of 25), Barts and Homerton are achieving better than peer group rates.
Planned Care: Elective Surgery

What is not working well?

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<tr>
<th>PRINCIPLE 1</th>
<th>Appropriate access to high quality surgery</th>
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<tr>
<td>Data shows variation in elective surgical spells across the CCGs e.g. age adjusted rates of surgery for gynaecology range between: 1,992 per 100,000 in Newham and 983 in City and Hackney. There is a lack of patient decision making aids in use, and patients and clinicians are not always fully aware of the options available to them.</td>
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<th>PRINCIPLE 2</th>
<th>Appropriate pre-operative care close to home</th>
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<tr>
<td>We know that in some areas there is a lack of agreement of how best to treat patients or how to assess clinical risk across Barts Health. In some specialties there is a lack of clear clinical guidelines and protocols for surgical risk assessment and on where patients would be best treated. There is no defined list of procedures for where complex cases should be treated across all specialties.</td>
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<tr>
<th>PRINCIPLE 3</th>
<th>Separation of elective and emergency surgery</th>
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<tr>
<td>Too many patients are having their operations cancelled across all sites. All cancellations are unacceptable from a patient point of view and we should aspire to cancel none. Total number of cancelled operations last year: • 775 at Barts and R London • 261 at Homerton • 553 at Newham • 816 at Whipps Cross These range from 10% cancellations in one specialty to 1.1% in another.</td>
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<th>PRINCIPLE 4</th>
<th>Day cases as the norm</th>
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<tr>
<td>There is still room for improvement on day case rates if we want to provide the best possible care. There is variability in the rate at which sites are performing operations as day cases, providing an opportunity to improve performance. E.g. Homerton performing inguinal hernia at 82% and Royal London Arthroscopy at 83% both of these are above peer.</td>
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<th>PRINCIPLE 5</th>
<th>Safe care, in the right place at the right time</th>
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<tr>
<td>There is an opportunity to strengthen local surgical and clinical offerings, while achieving better outcomes by agreeing where and when specialised delivery would be more effective. There is evidence to suggest that for some specialties, concentration of services leads to improved efficiencies and outcomes. In other cases it is may be better and possible to deliver services locally. Clinicians have discussed Colorectal, ENT and Urology as potential areas where improvements could be made.</td>
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<th>PRINCIPLE 6</th>
<th>Coordinated reablement and recovery</th>
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<tr>
<td>We know that some sites help people get home more quickly than others. There is large variance in average length of stay between sites across specialties e.g. two days’ difference in average length of stay for intermediate knee procedures (non-trauma without complication) between sites. Some of this may be due to the complexity of cases seen, but there is an underlying opportunity to improve this.</td>
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What are the constraints?

**Capacity:** Potential to move to higher utilisation in theatres

**Workforce:**
- Day case surgery needs to be seen as an attractive career proposition in its own right (still an emerging specialty in its own right)
- There is a need to ensure that surgery is arranged in a way that means junior surgeons training can still take place effectively
- Complexity in primary care means that primary care referrers may not be confident in educating patients on their full range of treatment choices
- European working time directive limits training and work commitments/opportunities

**Links to community:** Lack of communication/process to link with community rehab teams to enable enhanced recovery and timely discharge

**Clinical leadership:** There is a lack of clinical responsibly for the patient along the whole pathway.
The diverse nature of our population presents challenges for delivering health and social care. Locally, we have some of the highest levels of deprivation in England. For example, the inner north east London CCGs (i.e. City and Hackney, Newham, Tower Hamlets and Waltham Forest) have two times more deprivation than the national average and Hackney, Newham and Tower Hamlets are within the ten most deprived local authorities in the country. Deprivation is associated with poorer health outcomes, lower life expectancy, and higher incidence of obesity, drug and alcohol use. For example, in the inner north east London boroughs the number of hospital stays for alcohol-related harm is significantly worse than the England average and there has been a 50% increase in the number of hospital stays for alcohol-related harm per 100,000 population since 2009.

Our population is culturally diverse, with over 50% of the population in the inner east London boroughs belonging to black and minority ethnic communities. These communities are predisposed to have some long term conditions, such as diabetes and heart disease. Services must be set up to be flexible enough to meet the different cultural needs of the population. Language presents challenges for resourcing in primary care. 30% of patients in Tower Hamlets have English as a second language. Consultations for these patients are 1.9 times longer than for those who speak English. This has significant implications for primary care resourcing.

There is high level of population movement into and out of the borough, particularly in the inner east London boroughs which presents challenges for delivering local services. There is also a large unregistered population (e.g. A third of patients attending St Andrew’s Walk-In Centre in Tower Hamlets are unregistered and 30% of people who attend A&E are not registered with a GP). A significant number of people working in the inner north east London boroughs also require access to healthcare services while in the area. For example, there are estimated to be 350,000 people per day entering the City and 100,000 people in Canary Wharf who may require access to healthcare. Developments in the area, such as the E20 in Stratford, are likely to increase demands on healthcare services. There is also a large homeless population in some parts of east London. For example, in Tower Hamlets the Combined Homeless and Information Network (CHAIN) found that there were 326 rough sleepers in Tower Hamlets. This was an increase of 96 from 2008/9.

These factors are contributing to a high prevalence of chronic conditions and high levels of acute activity. For example, the prevalence of diabetes in Newham is almost four times the London average and A&E attendances are significantly higher than the national average in inner north east London (433.5 per 1,000 weighted population compared to a national median of 340.6). Over recent years, efforts to reduce avoidable emergency activity have shown results for example the number of emergency admissions have levelled off since 2012.

Benchmarking suggests that demand for emergency services is high in our boroughs and there is considerable variation across the patch. For example, A&E attendance rates per 1,000 population in all the CCGs in east London are higher than the London average. Emergency admissions rates per 1,000 population in City and Hackney and Waltham Forest are significantly higher than comparator boroughs (e.g. 114 per 1,000 population in Waltham Forest and City and Hackney compared to 95 per 1,000 population in Tower Hamlets). This suggests there is scope to reduce variation and improve services.

Service responsiveness also varies across the patch. The Homerton generally performs well on emergency care access standards, however Barts Health performance varies by site. Aggregate performance for Barts Health and the Homerton against the four hour A&E standard is 94.8% compared to 95.8% nationally. Waltham Forest has the highest proportion of non-elective bed days (85.255 in 2012/13), which is likely to be a reflection of its older age profile. The Royal London is the site with the highest number of emergency bed days (127,540 in 2012/13). Patient experience and access indicators are some of the worst in the country for GP services. For example, the combined GP access score across the five CCGs was 70% compared to a national average of 77%. There are also inconsistent arrangements for community support services. For example, in Newham there is 24 hour access to social care but this is not the case in Tower Hamlets and Waltham Forest.

These challenges are set to intensify as the population grows. The population in inner north east London, for example, is growing twice as fast as the London average. This will lead to an increase in the demand for healthcare services. The demographics of the local population are also changing. People are living longer with increasingly complex and often multiple long term conditions. The average age of the population is getting older and by 2020, for example, the over 65 year old population across all boroughs will grow by 15,439. The population will still be comparatively young compared with the rest of England and the largest growth will be in the 30-39 year old age band (30,000).

In summary there is a mismatch between our current model of unscheduled care and future population needs. There is a need for system-wide change. This can not be done by the health care system alone. Local authorities, local communities, patients and the public all have influence on health and healthcare and will need to be involved in future developments.
Unplanned Care

What does good look like?

**PRINCIPLE 1**

The future model of unscheduled care should work to promote planned care to help prevent unplanned contacts where they are avoidable

- Healthy lifestyles are promoted by local authorities, local businesses and local people
- Patients are responsible for their health and are supported to play a proactive part in maintaining their health and/or managing their own condition(s)
- Self-care/management is supported by a shared care plan that is actively monitored and underpinned by collaborative relationships that transcend organisational boundaries
- Self-care and self-management techniques are employed to help people manage their care in a planned way

**PRINCIPLE 2**

The future model of unscheduled care should support people with urgent care needs to get to the right advice, in the right place, first time

- The system should enable and support people to make the right decisions in the easiest way possible
- Access to expert advice, support and reassurance 24/7 via telephone and online (these services should help you to easily navigate the healthcare system)
- Clear, consistent and intuitive care pathways
- Access to greatly enhanced urgent care services outside of hospital, supported by the appropriate clinical support services and specialist expertise.

**PRINCIPLE 3**

The future model of unscheduled care should ensure that services for urgent, non-life threatening needs are delivered at or as close to home as possible

- Patients should not always have to travel to hospital to access specialist expertise
- Use of medical links to support care in the community
- Make use of technological advances to support more care being delivered at home
- More ‘hear and treat’ care (including 111, GP, LAS) and ‘see and treat’ (e.g. LAS) or using methods such as Skype
- Maximise community pharmacy
- Use of integrated health and social care teams to deliver care in people’s homes and in community settings

**PRINCIPLE 4**

Serious or life threatening needs should be treated in services with the best expertise and facilities to reduce risk, and maximise survival and good recovery

- Consolidated care for specialties and conditions where there is an evidence base that outcomes will improve from consolidation
- The base for consolidated services is determined by the appropriate support services rather than geographical location
- Services are equipped with the right facilities, equipment and resources and are staffed in the most appropriate way
- The same quality of care is available seven days a week
- Length of stay is dictated by clinical need not system inefficiencies
- Supported by robust social and community care arrangements

**PRINCIPLE 5**

The future model of unscheduled care should be delivered as a connected model of urgent and emergency care

- Interconnected model of care across the patch that allows for a full understanding of demand across the system and therefore proactive management of demand within allocated resources
- Supported by networked IT, information and resource sharing arrangements
- Includes community, social care and mental health providers as part of the network arrangements
- Everyone has the same level of access regardless of location e.g. access to information.

Supported by education, training and development and integrated IT systems

Financial incentives to drive best practice

What is working well at the moment?

- Social prescribing is a good example of preventative care. Provides clinicians with 11,000 non-medical sources of support for patients
- Flu vaccination coverage for over 65s is above the national median (74.9% compared to 73.8%)
- The Homerton performs well against the four hour A&E target; Barts Health has low length of stay for non-elective admissions (1 compared to a peer group average of 1.8); Readmission rates at Barts Health are below the CHKS peer group (12% compared to 13.3%)
- City and Hackney, a ‘ParaDoc’ service is being piloted which involves a paramedic and GP working to treat patients on the scene (referrals are screened by the clinical hub)
- There are pockets of good practice in using new technologies to access specialist expertise, such as Skype consultations in Newham
- 60% of out of hours calls dealt with over the phone in Newham
- Implementation of the Rapid Assessment Interface and Discharge (RAID) model at the Royal London has demonstrated good outcomes
- The Royal London Hyper Acute Stroke Unit offers significantly lower than average mortality rates – 12% compared with 20% nationally
- Trauma outcomes have improved over the last two years – 1.3 additional survivors out of every 100 patients

Everyone is responsible for reducing the need for, and pressure on, unplanned care services: patients and the public, local authorities, businesses and health services
### Unplanned Care

#### What is not working well?

<table>
<thead>
<tr>
<th>PRINCIPLE 1</th>
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<tbody>
<tr>
<td><strong>Planned health care promotion to prevent unplanned care</strong></td>
<td><strong>Right advice, in the right place, first time</strong></td>
<td><strong>Urgent care at or as close to home as possible</strong></td>
<td><strong>Specialist centres with the best expertise and facilities</strong></td>
<td><strong>Networked model of urgent and emergency care</strong></td>
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<tr>
<td>- CCGs in east London do not meet the national benchmark for people feeling supported to manage their condition (57.5% vs. 68.5%)</td>
<td>- The current system of unscheduled care is complex and confusing - multiple points of entry and different services behind the same names</td>
<td>- LAS suggest that 50% of 999 ambulance calls could be treated on the scene – dependent on access to onward pathways of care</td>
<td>- Improved outcomes from the consolidation of some services. E.g. Stroke outcomes at Barts Health are amongst the best in the country. The Royal London Hospital HASU offers significantly lower than average mortality rates – 12% compared with 20% nationally. There is potential to do this for other services</td>
<td>- Information systems do not provide oversight of demand across the whole health system</td>
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<tr>
<td>- Over 90% responded “no” when asked if they had a written care plan in place (GP Survey, 2014).</td>
<td>- The GP Out of hours and NHS 111 services are separate. There is poor coordination between these services.</td>
<td>- 5-8% of hospital admissions are the result of avoidable medicines related illnesses – community pharmacists could be utilised better</td>
<td>- IT systems do not support full information sharing across sites and levels of care e.g. there is no single set of electronic notes or linked medical record</td>
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</tr>
<tr>
<td>- Benchmarking shows that there is large variation in hospitalisations for chronic ambulatory care sensitive conditions – from 919 per 100,000 population in Waltham Forest to 314.5 per 100,000 population, compared to national average of 784 per 100,000 population.</td>
<td>- Access to GP services is poor (the bottom 25% nationally) for every CCG as measured by the GP patient survey.</td>
<td>- More could be done to maximise technology – over the phone telephone consultations reduced face-to-face contacts by 50% waiting times reduced from 5.5 days to same day</td>
<td>- Access to interventional radiology within 12 hours is not currently guaranteed across the patch</td>
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</tr>
<tr>
<td>- The proportion of physically active adults is below the national median (55.4% compared to 57.1% nationally).</td>
<td>- Poor coordination between these services.</td>
<td>- Newham UCC found that 30-40% of people attending could be treated closer to home</td>
<td>- There is potential to do this for other services</td>
<td>- Access to intervention radiology within 12 hours is not currently guaranteed across the patch</td>
</tr>
</tbody>
</table>

### What are the constraints?

- The lack of **communication and information sharing** across levels of care and organisational boundaries – compounded by lack of connectivity between IT systems
- The accessibility of primary care to support self-management, which is compounded by a **stretched primary care workforce**. The lack of infrastructure required to support the promotion of self-care and self management. This includes variable and **limited access to specialist expertise**, inconsistently joined-up medical records, lack of **technology to support self-care** and **perverse incentives** that inhibit a shift from a hospital setting to caring for people in their homes or primary care or integrate care across the health system
- **Poor systems to divert patients into support systems** coupled with public expectations about the timeliness of care. For example, on average patients only wait 50 minutes to be treated in A&E and the vast majority are treated within four hours – something that often is not offered in a primary care setting. There are inconsistent social and community care arrangements within each borough, with some operating 24 hour services whilst others do not
- **The role of local authorities and local communities in health promotion and prevention should not be underplayed**. Local authorities have a range of legislative and policy levers at their disposal, as well as an influence on the wider determinants of health. For example, some local authorities have planning restrictions in relation to the proximity of fast food outlets to schools, colleges, leisure centres and other places that children gather
- **Workforce**: There is a **declining primary care workforce**. In Newham there are approximately 90 fewer GPs than is required to serve the local population. Less than five district nurses qualified in London last year; and over the past decade there has been a 40% decline in those choosing to enter the profession nationally. **Workforce is also a constraint in the acute sector**, in relation to consultant cover in A&E and emergency surgery.
Clinical Support Services

Introduction

The role of the Clinical Support Services Clinical Working Group has been to look at pathology, imaging and hospital based pharmacy services. Further development of the pharmacy case for change will be taken forward in June to September.

Population growth and the growth of the number of people with long term conditions is a major factor in the demand for Clinical Support Services. In East London, our population is growing at a rate that is 50% faster than the London average. In WELC, 39-58% of patients have one or more LTC. This number is set to increase as the age of the population increases. Over the next 20 years, the population of over 65s will increase by 37,000 (60%) and form 9% of the population (GLA projections). Age is a major factor in the prevalence of LTCs therefore it is likely that the prevalence of some LTCs will increase for some conditions.

In addition, the prevalence of specific diseases is rising. For example, the prevalence of diabetes in East London is growing at a rate that is faster than the national average. In Newham the prevalence of diabetes will be 56.8% higher than the national average in 2030.

Increased emphasis on early diagnosis is also driving demand. This is coupled with a policy and clinical direction that emphasises early recognition, prompt diagnosis and treatment of LTCs. Based on these changes the demand for pathology services is predicted to rise. The current set up of services (capacity, workforce, infrastructure) is unlikely to be able to sustain such growth in a way that maintains quality and performance. In addition, increasing resources is unlikely to be a long term financially viable option.

In 2013/14 there were 15.9 million tests carried across Barts Health*. Demand varies significantly by referral source. 60% of pathology activity is generated internally (from A&E, inpatient, outpatient and sexual health clinics) and 36% of activity is generated from GP referrals. Waltham Forest, Newham and Tower Hamlets GPs generated approximately a third of activity each (31%, 30% and 28% respectively). Demand also varies by discipline. Internally, 70% of requests were for clinical biochemistry and 16% were for haematology. For GP generated requests, 80% of requests were for clinical biochemistry and 12% were for haematology.

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

Clinical Support Services

What does good look like?

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</thead>
<tbody>
<tr>
<td>Ensuring enough capacity to meet growing demand</td>
<td>High quality access to services</td>
<td>Clear and robust pathways of care</td>
<td>High quality and high performing services</td>
</tr>
</tbody>
</table>

A service with a clear plan in place to respond to changing demand with the resources that are available. Supported by evidence-based protocols to enhance early identification, diagnosis and treatment, but avoid unnecessary over investigation though having robust pathways in place.

A service that provides consistent high quality, and where clinically appropriate, local access to services, taking into account costs versus benefits to patients as well as implications for staff and service models. Ensuring equal access across all boroughs and 24/7/365 support to other services where required.

Clear and consistent, clinically driven patient pathways, supported by systems that allow full visibility of the end-to-end patient journey and provide early signals of any delays.

High quality and efficient services provided across all settings which support effective service delivery across all care pathways, intelligent reporting and timely access of results in a suitable format.

 INFORMATION TECHNOLOGY

IT systems that can interface within the acute setting and across primary and secondary care, support visibility of the patient journey across the full pathway, support delivery in a range of settings and support good communication. A service where opportunities presented by new technologies are maximised to deliver greater quality and efficiency.

 WORKFORCE

A happy, engaged and motivated workforce, which is flexible enough to work across different settings to support future models of care and respond to service demand.

What is working well at the moment?

- Barts Health and the Homerton consistently achieve the national target to complete diagnostic tests within six weeks of referral
- Pathology turnaround times are on the whole very good in terms of referral to test completed. E.g. on average 100% of C.Difficile tests are completed within four working days for GP and hospital referrals and 99% of HIV antibody tests are completed within 72 hours for GP and hospital referrals
- Direct access to pathology results via ‘Cyberlinks’ is in place in some CCG areas and is working well
- Open access for x-rays in Newham and Tower Hamlets, which means that patients can be seen on the same day as the referral
- B-type Natriuretic Peptide (BNP) testing for heart failure is in place in Waltham Forest. This enables GPs to diagnose heart failure in primary care settings.
- For patients who have a suspected lung cancer identified through a chest x-ray, the radiology services at Barts Health and the Homerton directly refer patients for further investigations, which avoids patients having to go back to their GP for referral to a consultant. A copy of the referral is sent to the cancer referrals unit so they can confirm arrangements with the GP. This is an informal arrangement, but it reduces delays in the patient pathway.
- Barts Health and Homerton provide Faecal Calprotectin testing, (a NICE recommended test) that helps doctors distinguish between inflammatory bowel disease and non-inflammatory bowel conditions. This means that most people with irritable bowel syndrome can be diagnosed without the need for invasive investigations.
**Clinical Support Services**

### What is not working well?

#### PRINCIPLE 1
**Demand**
- Demand is rising, due to the population and prevalence of long term conditions. For example, GLA population growth alone is projected to increase demand by 10.6%. This represents more two million extra tests in pathology between now and 2020/21. The current solution is to increase resources which is not, financially, a long term viable option.

#### PRINCIPLE 2
**Access**
- There is variation in access to support services across the boroughs. The majority of provision is acute based and predominantly within working hours.
- The quality of direct access providers is variable. Reports from acute clinicians indicate that imaging quality is variable and often results in repeat testing.
- Providing local access to diagnostics needs to be considered against: clear benefits to patients, ease of implementing community services, frequency of use of the service, economic impact, the effective use of workforce, impact on waiting times and impact on MDT working.
- Only the Royal London Hospital has reported that it has access to interventional radiology in line with London Quality Standards indicating the need for better networks to access this service.
- Access to new technologies needs to be balanced with an assessment of appropriate use.

#### PRINCIPLE 3
**Pathways**
- No visibility of the full pathway for support services: in particular the report back to the referrer and communication to the patient parts of the pathway.
- For radiology this is demonstrated by the reporting backlog at the Barts and the London site (as of April 2014, 550 exams waiting over six weeks to be reported). There is currently no sustainable solution to resolve this issue.
- The amber alerts and service alerts systems that are set up in Newham and Tower Hamlets respectively demonstrate that there are quality issues with the report to referrer part of the pathway.
- Lack of formalised pathways for some specialties that would smooth out the patient journey e.g. direct referral from radiology to some cancer clinics.
- Opportunity to develop IR pathways.

#### PRINCIPLE 4
**Quality and Performance**
- There is variation in the performance across sites for both pathology and radiology. E.g. variation in turnaround times by site for pathology and reporting backlog for radiology.
- The amber alerts and service alerts systems illustrate problems with getting the right results, being able to obtain results at all and errors in testing. These errors impact on clinicians being able to proactively act on results and consume time in chasing results or following up errors.
- These quality reporting systems are not in place across all boroughs and responses to queries raised are of variable quality. E.g. local audit of service alert responses in Tower Hamlets showed vague responses with unclear actions.
- Outsourced providers vary in quality — quality assurance of providers is critical.

### What are the constraints?

#### WORKFORCE:
- Workforce challenges including a lack of time and space to undertake training and development and some challenges in recruiting to key posts. There are some pockets of recruitment and retention issues e.g. staff turnover for support services (CSS) in Barts Health is 16.7% compared to the trust average of 12.8%. It is the highest of all the CWG areas. There is also higher than average number of staff disengaged in the work of Barts Health as reported by the staff survey.
- There is a lack of clarity regarding requirements to provide 24/7 services across sites and what is needed to achieve this. For example, most routine diagnostic work is provided Monday to Friday 9-5pm, which is not necessarily convenient for most patients. Primary care staff could be better supported through education, advice and guidance regarding appropriate referral and use of CSS. This could extend to provision of some CSS services e.g. Point of care testing and secondary care pharmacy support in primary care.

#### INFORMATION TECHNOLOGY:
- A lack of IT systems that communicate with each other and interface across sites and manual processes still in operation at some sites.
- A lack of IT infrastructure to support delivery of CSS in the community – e.g. visibility of test results/images in the community is patchy and variable. Information needs to be two way.
- A lack of visibility of the full end-to-end patient pathway.
- A mismatch between new technological opportunities and commissioning intentions. This is compounded by a lack of fora that bring together commissioners and providers to continuously review services in respect of CSS. The CWG feels that commissioners should take the lead on setting up these fora.