Public Document Pack

JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE AGENDA

2.00 pm	Tuesday 19 April 2016	Waltham Forest Town Hall

COUNCILLORS:

LONDON BOROUGH OF BARKING & DAGENHAM

Councillor Peter Chand
Councillor Eileen Keller
Councillor Adegboyega Oluwole

LONDON BOROUGH OF WALTHAM FOREST

Councillor Anna Mbachu
Councillor Tim James
Councillor Richard Sweden (Chairman)

LONDON BOROUGH OF HAVERING

Councillor Nic Dodin
Councillor Dilip Patel
Councillor Linda Van den Hende

ESSEX COUNTY COUNCIL

Councillor Chris Pond

LONDON BOROUGH OF REDBRIDGE

Councillor Stuart Bellwood
Councillor John Howard
Councillor Karen Packer

EPPING FOREST DISTRICT COUNCIL

Councillor Gavin Chambers (Observer Member)

CO-OPTED MEMBERS:

Ian Buckmaster, Healthwatch Havering
Mike New, Healthwatch Redbridge
Richard Vann, Healthwatch Barking & Dagenham
Alli Anthony, Healthwatch Waltham Forest

For information about the meeting please contact:
Anthony Clements
anthony.clements@oneSource.co.uk 01708 433065

Protocol for members of the public wishing to report on meetings of the Outer North East London Joint Health Overview and Scrutiny Committee

Members of the public are entitled to report on meetings of the Joint Committee, except in circumstances where the public have been excluded as permitted by law.

Reporting means:-

- filming, photographing or making an audio recording of the proceedings of the meeting;
- using any other means for enabling persons not present to see or hear proceedings at a meeting as it takes place or later; or
- reporting or providing commentary on proceedings at a meeting, orally or in writing, so that the report or commentary is available as the meeting takes place or later if the person is not present.

Anyone present at a meeting as it takes place is not permitted to carry out an oral commentary or report. This is to prevent the business of the meeting being disrupted.

Anyone attending a meeting is asked to advise Democratic Services staff on 01708 433076 that they wish to report on the meeting and how they wish to do so. This is to enable employees to guide anyone choosing to report on proceedings to an appropriate place from which to be able to report effectively.

Members of the public are asked to remain seated throughout the meeting as standing up and walking around could distract from the business in hand.

NOTES ABOUT THE MEETING

1. HEALTH AND SAFETY

The Joint Committee is committed to protecting the health and safety of everyone who attends its meetings.

At the beginning of the meeting, there will be an announcement about what you should do if there is an emergency during its course. **For your own safety and that of others at the meeting, please comply with any instructions given to you about evacuation of the building, or any other safety related matters.**

2. CONDUCT AT THE MEETING

Although members of the public are welcome to attend meetings of the Joint Committee, they have no right to speak at them. Seating for the public is, however, limited and the Joint Committee cannot guarantee that everyone who wants to be present in the meeting room can be accommodated. When it is known in advance that there is likely to be particular public interest in an item the Joint Committee will endeavour to provide an overspill room in which, by use of television links, members of the public will be able to see and hear most of the proceedings.

The Chairman of the meeting has discretion, however, to invite members of the public to ask questions or to respond to points raised by Members. Those who wish to do that may find it helpful to advise the Clerk before the meeting so that the Chairman is aware that someone wishes to ask a question.

PLEASE REMEMBER THAT THE CHAIRMAN MAY REQUIRE ANYONE WHO ACTS IN A DISRUPTIVE MANNER TO LEAVE THE MEETING AND THAT THE MEETING MAY BE ADJOURNED IF NECESSARY WHILE THAT IS ARRANGED.

If you need to leave the meeting before its end, please remember that others present have the right to listen to the proceedings without disruption. Please leave quietly and do not engage others in conversation until you have left the meeting room.

AGENDA ITEMS

1 CHAIRMAN'S ANNOUNCEMENTS (Pages 1 - 4)

The Chairman will announce details of the arrangements in case of fire or other events that might require the meeting room or building's evacuation.

A map and directions to the venue are attached.

2 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies have been received from Councillor John Howard, London Borough of Redbridge.

3 DISCLOSURE OF INTERESTS

Members are invited to disclose any interests in any of the items on the agenda at this point of the meeting. Members may still disclose an interest in an item at any point prior to the consideration of the matter.

4 MINUTES OF PREVIOUS MEETING (Pages 5 - 12)

To agree the minutes of the Joint Committee held on 19 January 2016 (attached) and to authorise the Chairman to sign them.

5 PRE-EXPOSURE PROPHYLACTICS

Discussion with a representative from Barts Health NHS Trust on the Pre-Exposure Prophylactic method of HIV prevention.

6 TRANSFORMING SERVICES TOGETHER (Pages 13 - 66)

Officers will present on the Transforming Services Together proposals which are currently the subject of public engagement. Report, summary of proposals and engagement plan attached.

7 MOORFIELDS HOSPITAL MOVE PROJECT

Tim Fry, Director of Capital Investment, Moorfields Eye Hospital NHS Foundation Trust, will update the Committee on the hospital move project.

8 PROVISIONAL ITEM: GP PRIMARY MEDICAL SERVICES CONTRACTS

To receive an update from officers on the review of Primary Medical Services contracts for GPs in Outer North East London.

9 URGENT BUSINESS

To consider any other item of which the Chairman is of the opinion, by means of special circumstances which shall be specified in the minutes, that the item be considered as a matter of urgency.

Anthony Clements
Clerk to the Joint Committee

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Waltham Forest Council and Committee Meetings

All Council/Committee Meetings are held in public unless the business is exempt in accordance with the requirements of the Local Government Act 1972.

Most meetings are held at Waltham Forest Town Hall which is an accessible venue located in Forest Road E17 between Waltham Forest Magistrates Court and Waltham Forest College. The nearest underground and railway station is Walthamstow Central which is approximately 15 minutes walk away from the Town Hall. Buses on routes 275 and 123 stop outside the building.

There is ample parking accommodation for visitors for meetings held at Waltham Forest Town Hall including parking bays for people with disabilities.

There is a ramped access to the building for wheelchair users and people with mobility disabilities.

The Council Chamber and Committee Rooms are accessible by lift and are located on the first floor of Waltham Forest Town Hall.

Induction loop facilities are available in most Meeting Rooms.

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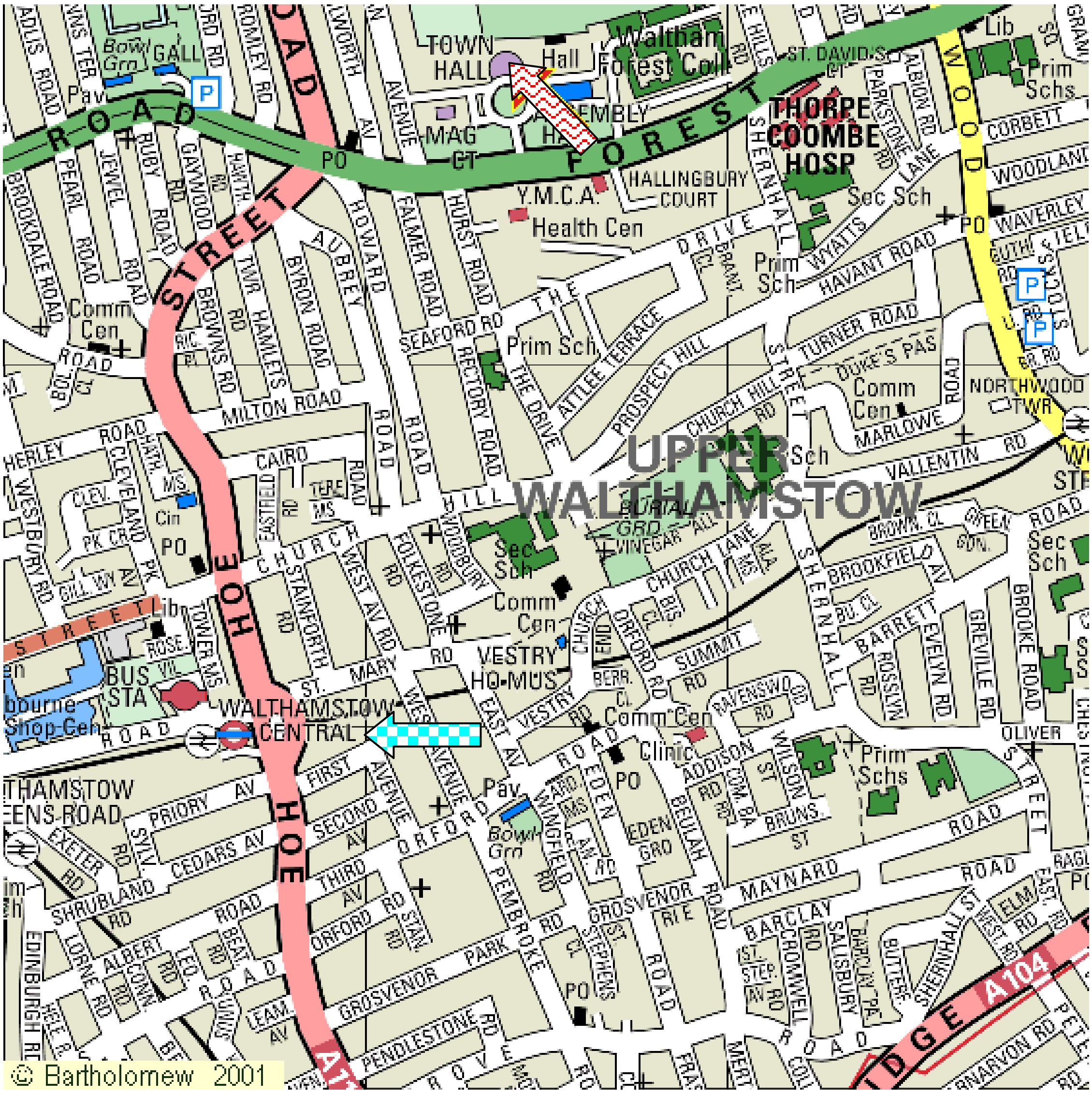

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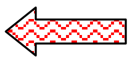
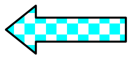
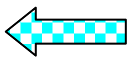
WALTHAM FOREST TOWN HALL: Forest Road Walthamstow London E17 4JF **Town Hall Reception Desk** 020 8496 4671 **Switchboard** 020 8527 5544 **Direct Contact** Mr Knight 020 8496 4736	
Nearest London Underground station: Walthamstow Central is on the Victoria Line. Take a cab or bus from the station – or it is a 15-20 minute walk to the Town Hall.	
Nearest London Overground Railway station: From Liverpool Street Railway Station to Walthamstow Central. Take a cab or bus from the station – or it is a 15-20 minute walk to the Town Hall.	

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MINUTES OF A MEETING OF THE
JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Redbridge Town Hall, Ilford
19 January 2016 (2.00 - 3.57 pm)

Present:

COUNCILLORS

Havering	Nic Dodin, Gillian Ford and Dilip Patel
Redbridge	Stuart Bellwood, John Howard (Chairman) and Karen Packer
Waltham Forest	Richard Sweden
Essex	Chris Pond

Co-opted Members
Ian Buckmaster,
Healthwatch Havering
Mike New, Healthwatch
Redbridge

Also present:
Cathy Turland, Healthwatch Redbridge
Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Kathryn Halford, Chief Nurse, BHRUT
Rachel Royall, BHRUT
Jan Stevens, Interim Chief Nurse, Barth Health NHS Trust
Jo Carter, Barts HealthNHS Trust
Dr Russell Razzaque, Consultant Psychiatrist and Associate Medical Director, North East London NHS Foundation Trust (NELFT)
Zoe Anderson, Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs)
Dr Sarah Hayes, Barking & Dagenham, Havering and Redbridge CCGs

Anthony Clements, Havering (minutes)
James Holden, Waltham Forest
Paul Umfreville, Redbridge

One member of the public was also present.

All decisions were taken with no votes against.

19 CHAIRMAN'S ANNOUNCEMENTS

The Chairman gave details of arrangements in case of fire or other event that may require evacuation of the meeting room.

20 APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS (IF ANY) - RECEIVE.

Apologies were received from Councillors Peter Chand and Eileen Keller (Barking & Dagenham) and Gavin Chambers (Epping Forest).

21 DISCLOSURE OF PECUNIARY INTERESTS

There were no interests disclosed.

22 MINUTES OF PREVIOUS MEETING

The minutes of the meeting of the Committee held on 20 October 2015 were agreed as a correct record and signed by the Chairman.

23 NURSING SHIFTS

The Chief Nurse at BHRUT explained that nurses at the Trust worked a variety of shifts and a system of long days with 12.5 hour shifts was available. This included one hour of breaks, split throughout the day. Around 20% of nurses sometimes worked this shift pattern but there was a mixed model available to staff.

Staff were only allowed to work two long days or four long nights in succession and the Chief Nurse felt this was a safe level. Two successive days off were required to be taken each week and staff got at least one weekend in every four off work.

Family commitments meant that some staff often preferred to work 2-3 long days each week and this could also reduce costs of childcare and commuting. Full-time employees at BHRUT worked 37.5 hours per week and were not permitted to work in excess of 48 hours per week unless they had signed a special opt out clause. These cases were also monitored by the Trust.

The Barts Health Interim Chief Nurse explained that offering a variety of shifts was the recognised norm across the NHS. The large numbers of nursing vacancies was also a challenge. The Trust was also aware of the risks of staff making mistakes if they were too tired and had similar controls in place to prevent people working excessive hours. Approximately 20-25% of staff at BHRUT had signed to work in excess of 48 hours per week although no staff were permitted to work more than 56 hours at the Trust in one week.

Both Trusts used e-rostering systems which ensured that staff had the required breaks of at least 11 hours built in. Continuity of care needed to be established across shifts and it was felt that this was the responsibility of the Sister in charge of the ward and how they built the nursing team. Officers agreed that it was important that the handover between shifts was robust enough to ensure that all key information was shared. Ward teams comprised 35-50 people and it was felt the availability of longer shifts encouraged the recruitment and retention of permanent staff and hence better continuity of care.

It was confirmed that the shift patterns were available to all grades of ward staff. Clinical nurse specialist working in clinics were likely to work more of a Monday – Friday, 9 am to 5 pm pattern. Senior nurses above Sister level tended to work a longer shift pattern.

It had been proposed by the Secretary of State to remove bursaries from nurses entering training although this had not been finally agreed as yet and would not impact on the two Trusts until at least 2017. Both Trusts had their own schemes to support nurses to train. The Royal College of Nursing had recently launched its own consultation on this issue and officers would obtain further details. It was noted that universities had in fact supported the ending of bursaries as there were 5-10 applications for each nursing place. Officers agreed however that proper discussion was needed before any changes were made. The BHRUT Chief Executive added that he would welcome further discussion on this issue and suggested this be considered by the Trust's Local Representative Panel.

The Portuguese nurses recruited to BHRUT had been settling in well and further recruitment exercises in Europe were planned by the Trust. Recruitment from the Philippines was also being considered. Barts Health had also recruited a lot of international nurses for whom there was dedicated support available. BHRUT held interviews face to face (in English) and insisted that nurses recruited could both speak and understand English. Barts Health also required nurses to sit an exam in English. Support at both Trusts was given to foreign nurses not just in understanding medical terminology and general orientation but also in practical issues such as opening a bank account.

All newly qualified nurses underwent an 18 month induction programme at Barts Health and spent two weeks on training and development before being counted as part of the ward staff. New staff were also supported by the Ward Sister and via a buddy system.

The option of long shifts was also available in training and a balance of experience was sought on ward rosters. There were not specific figures kept of the ratio of trained to training nurses on wards. The number of nurses and Health Care Assistants on wards was however monitored twice a year and this information was published on the NHS Choices website. These audits looked at professional judgements of what constituted an appropriate

nursing level and had recently led to an agreement to recruit 500 further nurses across Barts Health. Daily Safety Huddle meetings also allowed for a response if staffing levels were down.

The number of nursing training places had already gone up following a national review of workforce planning. The rising age of the nursing workforce was also an issue and it was noted that a new grade of Associate Nurse (above Health Care Assistant) was also being introduced.

It was suggested that if Members had further concerns re the number of training places, representation could be made on this matter to Health Education England. A Member added that she could raise this matter with colleagues on the Community Wellbeing Board of the Local Government Association.

The Committee **NOTED** the presentations and thanked officers for their input to the meeting.

24 **OPEN DIALOGUE TREATMENT**

The Associate Medical Director at NELFT explained that the cost of mental ill health to society was likely to double over the next 10 years. Funding for services was also reducing so it was necessary to look at more cost effective ways of providing services.

NELFT managed most people in the community and hence had the second lowest bed base in the UK. Studies had shown that people who had better social and family networks had better mental health outcomes in the long run. The National Institute of Clinical Excellence had therefore recommended that more family therapy should be provided but there were cost implications to this. A survey by the Care Quality Commission had shown that only 58% of service users had family or friends involved in their care.

The Open Dialogue technique had started in Finland where staff had been trained in family therapy and related skills. A patient's family was at the heart of the care provided and this led to better outcomes. 74% of people treated under Open Dialogue were discharged within two years. The system was now used throughout Scandinavia and also in Germany and the USA.

The core principles of Open Dialogue included the provision of immediate help and the involvement of social or family networks. It was also important to ensure psychological continuity with the same team responsible for a person's treatment. Therapists were also trained to use the dialogism technique whereby everyone's voice was able to be heard.

Open Dialogue also allowed the flexibility and mobility for a user to take charge of their own care. Clinicians were also trained in the Mindfulness technique and made use of peer support whereby people with experience of mental health issues joined the team.

A proportion of mental health teams in Havering and Waltham Forest had now been trained in Open Dialogue and it was proposed to roll out the service to the rest of the NELFT area over the next year. NELFT training in Open Dialogue comprised a four week residential course which trained its first cohort of students in October 2015. Approximately 90 further members of staff were due to be trained this year. A post-graduate diploma in this area was also being developed with London South Bank University.

Initial feedback from service users had been very positive with patients becoming advocates for the service and considerable positive press coverage being generated. Staff reaction had also been very positive. The Department of Health had also shown interest and full roll out of Open Dialogue in trial areas would take place by January 2017.

Referrals would be made to the Open Dialogue staff instead of to a mental health crisis team. It was noted that in other countries communities had successfully developed of people with similar mental health issues. Similar communities were also now seen in Nottingham and Somerset. The Open Dialogue Technique was supported by the Care Act and officers agreed that it was important that service users received continuity of care.
Costs of the Open dialogue technique would be monitored and it was accepted that costs at the outset may be higher than alternative treatments. The Associate Medical Director felt however that the technique would reduce the costs of services in the long term. It was emphasised that the same team would be able to continue to treat people as in-patients.

It was **AGREED** that open dialogue be scrutinised again by the Committee at its meeting in January 2017 in order to consider the results of the trial of the service.

25 **PROPOSED CHANGES TO STROKE REHABILITATION SERVICES**

The clinical director for the project explained that current stroke services were variable and resulted in a ‘postcode lottery’. There were for example in-patient units at Beech ward, King George Hospital and Grays Court in Dagenham, with different providers, which was a confusing situation for patients. This was a factor explaining why patients in this sector spent longer periods in hospital and had longer recovery times.

Commissioners wished to see a gold standard quality of care across Outer North East London but national standards were not currently being met consistently. There was also not sufficient capacity in the system to meet future demand for stroke services. This demand was likely to rise by around 35% in the future.

A case for change for stroke services had been developed and a workshop held with stakeholders. This had established a preferred option based on improved patient outcomes. This would combine early supported discharge

with community rehabilitation services across all three affected boroughs, together with an in-patient unit at King George Hospital. These services would all be supplied by a single provider. It was felt that this model would allow for improved patient outcomes and also allow the best value for money.

There was currently in progress a 12 week consultation period which would include on-line questionnaires and hard copies of documents being available in GP surgeries. There would also be drop-in sessions arranged for each borough and work was also being undertaken with the relevant Healthwatch organisations. The consultation was due to close on 1 April 2016. All responses would be considered and the final decision would be made by the three CCG governing bodies.

The impact of the preferred option on Barking & Dagenham would mean more patients receiving care at home and any in-patients being treated at King George Hospital. The future of the Grays Court facility would be decided in conjunction with London Borough of Barking & Dagenham. The impact on Redbridge would be similar with Wanstead residents receiving support from the Early Supported Discharge service which would provide services such as speech and language therapy and psychotherapy. The new arrangements would operate in a similar way within Havering. It was noted that Redbridge stood to gain the most under the new arrangements, particularly in the Wanstead and Woodford areas.

A representative of Healthwatch Redbridge confirmed that the organisation had been fully involved and had worked on producing an accessible version of the consultation documents. Healthwatch Redbridge was happy with the methods used in the consultation and pre-consultation exercises.

Officers were currently establishing what was considered best practice around staffing levels, bed numbers etc but were confident that sufficient staff could be attracted to make the model function successfully.

It was confirmed that the former Heronwood & Galleon inpatient unit for intermediate care in Wanstead had now closed.

Councillor Pond explained that the Essex Health Overview and Scrutiny Committee had supported the move of first stage stroke treatment from Harlow to Queen's Hospital. In-patient treatment would also move from Epping to Harlow. Officers admitted that there was some uncertainty around cross-border issues and would check if Essex residents living near the site would be able to use the stroke in-patient beds at King George Hospital. The outcome of this could be reported back to the Essex Health Overview and Scrutiny Committee.

The Committee **AGREED** their support for the proposals to change stroke rehabilitation services subject to the outcome of the consultation and confirmation of the situation regarding Essex residents.

26 HEALTHWATCH REDBRIDGE - ENTER AND VIEW VISITS

The Chief Executive Officer of Healthwatch Redbridge explained that the organisation currently had a total of 61 enter and view reports, 46 of which looked at the issue of GP complaints systems. Other issues covered included access for deaf people in A & E departments, intermediate care and promoting dignity in health and care.

All GP practices in Redbridge had been visited regarding their complaints procedures. Two thirds of practices had been found to have information on their complaints procedures on display but a lot of information such as phone numbers or references to the now closed Primary Care Trusts was out of date. A number of practice staff had been found to have little knowledge of the relevant practice's complaints system and other practices' systems were too complex with for example only written complaints being responded to.

Healthwatch had made recommendations that all GP practices should update and simplify their complaints processes and also make complaints information accessible in alternative formats. Healthwatch Redbridge was also assisting Healthwatch England and the Ombudsman with national work on complaints handling and had been invited to present at a national conference on this subject.

Deaf inclusion work had covered 13 London boroughs and been funded by Health Education England. Healthwatch Redbridge had therefore trained 17 deaf volunteers to undertake enter and view visits. Accessible videos had been produced and Healthwatch Redbridge had led a stakeholder conference on this area. A & E departments at Queen's, Newham and University College Hospitals had been visited to look at barriers for deaf people. Queen's had been ranked the best in this regard.

Outcomes from the enter and view work had included that further funding had been secured from Health Education England. Healthwatch Redbridge now wished to work with other groups with sensory difficulties such as visual, brain injuries and stroke sufferers. Engagement work was also in progress with the Vanguard sites re disabled access and Healthwatch Redbridge had won three national awards for this work.

On intermediate care, the profile of this area had been raised through scrutiny work and Healthwatch Redbridge had made recommendations regarding more carer and patient involvement. It was accepted that there was further work to be undertaken on this area.

A total of ten enter and view visits had been undertaken looking at dignity in health and care. Healthwatch Redbridge had run a conference on the outcomes of this work and was planning a day event on 1 February 2016. A

public event re the consultation on stroke rehabilitation services was also being planned.

27 **URGENT BUSINESS**

There was no urgent business raised.

Chairman

Joint Health Overview and Scrutiny Committee

19 April 2016

Subject Heading:	Update on the Transforming Services Together programme's formal engagement period
Report Author and contact details:	Don Neame Director of Communications, NEL CSU & Transforming Services Together don.neame@nhs.net 0771 209 7659
Policy context:	Transforming Services Together aims to create safe, sustainable and high-quality health and care services to residents in east London.
Financial summary:	This strategy recommends initiatives that contribute to the health economy in east London (Waltham Forest, Newham and Tower Hamlets) being more financially sustainable over the next five years.

1. Summary

Transforming Services Together (TST), a partnership programme of work between Tower Hamlets, Waltham Forest and Newham CCGs and Barts Health Trust has published its Strategy and Investment Case. A period of public engagement began on 29 February and will run until 22 May 2016. Given the potential impact, stakeholders from each CCG, Barts Health Trust, patients and clinicians have been involved. The Strategy and Investment Case recommends investing in care close to home, new models of care at hour hospitals, more modern facilities and developing new ways of working.

Appendices

There are three parts of the report and an engagement strategy. Part one of the report (the summary) and the engagement strategy are attached.

Background papers

Parts two and three of the report are available for download here:
http://www.transformingservices.org.uk/strategy-and-investment-case.htm

2. Recommendations

The Joint Health Overview and Scrutiny Committee is recommended to:

- Note the publication of the strategy and engagement plan
- Provide initial views; and
- Take part in the engagement period both by making a formal response to the engagement and encouraging others to make their views known.

3. Report detail

The case for change

If we don't change, due to population growth, the health economy in Tower Hamlets, Waltham Forest and Newham will need an additional 550 inpatient beds by 2025 – the equivalent of a new hospital. The cost of building this capacity would be about £450 million; the cost of running these additional beds would be about £250 million a year. We would not have (or be able to recruit) the workforce to support this, and we know that hospital is not the right place for many people. If we don't change, the health economy finances will deteriorate further, patient experience will decline and patient safety will be put at risk. People will need to wait longer for operations or travel outside of east London for some routine elective care. People with a mental health illness will continue to be poorly treated compared to patients with a physical illness; too many people will continue

to die in hospital rather than in a homely surrounding. Patients and staff will have to cope with poor environments.

The strategy:

- Makes it easier for organisations to work together with common objectives and shared ideas;
- Aims to shift activity into fit-for-purpose settings of care, often closer to home;
- Will enable better prevention of ill health; helps people to stay healthier and manage illnesses;
- Will improve access to high quality, appropriate care;
- Focuses some specialisms in fewer locations to improve patient outcomes and experiences;
- Reduces bureaucracy; and
- Helps set our finances on a path of sustainability in an increasingly challenging environment.

Over the next five years we will focus attention on the following carefully considered, costed and tested high-impact proposals:

1) Improving access, capacity and coordination in **primary care** – empowering patients to take more control of their health;

2) Expanding **integrated care** to those at moderate risk of hospital admission, providing care in the patient's own home or in the community to help them stay well or manage their illness;

3) Putting in place an integrated model of **urgent care** – developing a single point of access with the ability to appropriately redirect patients to self-care services and/or book patients into local clinical services; and

4) Improving **end-of-life care** through better partnership working, sharing of care plans and more community services.

We recognise the need to strengthen our hospitals (the Royal London, Whipps Cross and Newham) and help them be sustainable. We will:

5) Establish **surgical hubs** – creating centres of excellence at each hospital by bringing together surgical services to reduce waiting times and cancelled operations;

6) Establish **acute care hubs** at each hospital – bringing together clinical areas focused on initial assessment, rapid treatment and recovery so more people can be seen and treated without the need for hospital admission; and

7) Increase the proportion of **natural births** (usually midwifery led) by enabling more informed choice and continuity of care.

For Waltham Forest and Redbridge residents, this will mean strengthened A&E and maternity services at Whipps Cross and a proposal to develop the hospital with partners (subject to funding). Some people may have to travel to Newham Hospital or the Royal London for some surgery but outpatients will still be local.

We will also work together to tackle bureaucracy and inefficiency in the NHS and improve patient experiences through:

8) Reducing **unnecessary testing** by considering whether GPs can refer straight to hospital and improving IT to enable test sharing;

9) Transforming the **patient pathway and outpatient services** by improving the quality of referrals so people don't have to travel unnecessarily and making better use of technology;

10) Developing a strategy for the future of **Mile End Hospital**;

11) Developing a strategy for the future of **Whipps Cross Hospital**;

12) Delivering **shared care records** across organisations – making records secure and more accessible;

13) Exploring the opportunity that **physician associates** may bring – examining how these, and other new roles, can relieve the pressure on GPs, as well as seeking to improve recruitment

Involvement and engagement

So far, more than 1,000 people have been involved in developing the plans. For example:

- The TST Patient and Public Reference Group;
- Clinical workshops and GP groups;
- Local organisations (e.g. NELFT, ELFT, Tower Hamlets CCG, local authorities, overview and scrutiny committees including Waltham Forest OSC on 15 March 2016);
- Existing meetings (e.g. maternity services liaison committee); and
- Specific patient/public meetings (e.g. diabetes workshop; mental health workshop; care records workshop).

We are now providing a wider opportunity to discuss the proposals with the public, staff and stakeholders between 29 February and 22 May 2016. We intend to inform people and enable them to have their say using: a mail/email shot; advertisements; press releases; posters; and drop-in sessions in the community and hospitals. We will also be organising local workshops on particular elements of the programme.

The full engagement strategy is included in background papers.

4. Implications and risks

4.1. Financial implications and risks:

Significant investment is required if we are to 'invest to save' so we have developed detailed analysis of the savings that could be achieved, with appropriate sensitivity analysis. Our assessment is that the programme could save between £104 million and £165 million revenue costs over a five year period, with annual savings thereafter of £48 million. Assessment of the capital requirements show that without TST (and therefore the need to build an extra 550 beds), the partners (and external resources yet to be accessed, e.g. national funds) would need to invest £352 million over five years and £1.1 billion over 10 years. However if the TST objectives are achieved the investment reduces to £173 million over five years and £636 million over 10 years. Both sets of figures include a cost of around £450 million over 10 years to rebuild Whipps Cross hospital.

4.2. Legal implications and risks:

N/A

4.3. Human Resources implications and risks:

Some of the proposals from the Transforming Services Together programme involve new roles and people working differently.

4.4. Equalities implications and risks:

Reducing health inequalities is a key theme of the Transforming Services Together programme. Any future service changes arising from the programme will be subject to Equality Impact Assessments.

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Transforming Services Together

Strategy and investment case

Part 1: Summary

NHS Newham Clinical Commissioning Group

NHS Tower Hamlets Clinical Commissioning Group

NHS Waltham Forest Clinical Commissioning Group

Barts Health NHS Trust


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Foreword

Transforming Services Together aims to improve local health and social care in Newham, Tower Hamlets and Waltham Forest – very much in line with the challenges of the NHS Five Year Forward View[1], local and regional plans and guidance[2].

Celebrating success

This document focuses on where we need to improve. But it's important to recognise some of the NHS's huge achievements in the past 20 years and appreciate the efforts of everyone working in health and social care.

For example, at the Royal London Hospital, we have one of the best trauma centres not just in the country, but in the world. We've also improved the quality and accessibility of our primary care services. Our services for tuberculosis, mental health, carers, and our websites and management have all been nationally recognised.

Stroke care is exceptional and survival ratios at our hospitals (a key measure of how safe services are) are among the country's best.

By working together we are ensuring local people are far more likely to survive conditions like heart disease than people in many other parts of the country[3].

A partnership approach

However, we also face complex challenges: a rising population; financial and workforce pressures; and in some cases poor patient care, buildings and infrastructure.

Where we live, our environment and our socio-economic situation are critical for wellbeing. We recognise the responsibility of local authorities for the health and wellbeing of their populations. We also recognise the responsibility of patients to make efforts to stay well, and how this could reduce the burden on the health service.

Together we have developed proposals that respond to some of the challenges and take advantage of the opportunities we face. Clinicians have led the discussions, in partnership with key stakeholders and members of the public. We welcome the honesty everyone has shown in reflecting on what is wrong with the existing system. We also welcome their dedication to developing new ideas on how to make the changes that are clearly needed.

We are encouraged by the enthusiasm for change, the willingness of all partners to work together and the strong belief that solutions can be found. More than a thousand people have taken part so far – we thank every one of them.

1 NHS England www.england.nhs.uk/ourwork/futurenhs/
2 London Health Commission www.londonhealthcommission.org.uk/better-health-for-london/
3 Health and Social Care Information Centre. January 2015 www.hscic.gov.uk/pubs/shmijul13jun14

We want to develop a new partnership with local people: it is your NHS, and we know it is a much-valued and respected institution. The health service, staff, partners, patients and residents need to work very differently with each other, and everyone has a part to play.

Our plan

This document outlines the main health and social care changes and investments needed in East London. We have set out a credible plan to transform the services that almost one million people (and rising) rely on. We must ensure we provide the patient experience that people expect, and the services that keep them well and safe. Most importantly, these changes will reset the system on a path towards financial sustainability.

We look forward to hearing from you.

Dr Prakash Chandra
Chair, Newham CCG

Dr Sam Everington
Chair, Tower Hamlets CCG

Dr Anwar Khan
Chair, Waltham Forest CCG

John Bacon
Chair, Barts Health NHS Trust

About Transforming Services Together

The Transforming Services Together programme is run by Newham, Tower Hamlets and Waltham Forest Clinical Commissioning Groups (CCGs) in partnership with Barts Health NHS Trust.

How you can help

We are now testing our ideas with staff, local communities, partners and patient representatives through drop-in events, focus groups, meetings and other methods.

This summary and the full document are intended to stimulate debate. To get involved or make your views known, please contact us:

☎ **020 3688 1540**

✉ **TransformingServicesTogether@nelcsu.nhs.uk**

www.transformingservices.org.uk

or fill in the questionnaire at the back of this summary.

We look forward to hearing from you.

Deadline for comments

We'll continue to involve people as these proposals develop, but we'll be finalising this Strategy and Investment Case in the summer of 2016. So we need your comments back by **22 May 2016** to help us at this stage of the process.

How to see the full document

To view the full document, please look at our website or contact us for a paper copy.

Who helped to develop the plan?

The plan has been developed with patients, the public and their representatives across East London. By 'East London', we mean the boroughs of Newham, Tower Hamlets and Waltham Forest, which are the focus of this strategy.

Over 300 health and social care staff (for instance surgeons, pharmacists, midwives, nurses, GPs, practice managers, healthcare assistants and managers) have also been involved from Barts Health; neighbouring CCGs (in particular, City and Hackney CCG, Barking and Dagenham CCG, Havering CCG and Redbridge CCG); Homerton University Hospital NHS Trust; East London NHS Foundation Trust; North East London NHS Foundation Trust; local authorities (including their public health teams) – in particular the London boroughs of Newham, Tower Hamlets, Waltham Forest, and Redbridge; NEL Commissioning Support Unit; NHS England – responsible for specialised commissioning; and the Trust Development Authority.

Challenges we face

The future challenge means the NHS and social care has to change

Our population is projected to grow considerably. Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest will probably grow by 270,000 – the size of a new London borough. We anticipate thousands more births each year and, as people live longer, so their health and social care needs will also increase.

But we are close to reaching the capacity of our buildings if we continue working in the same ways. If we don't change, we'll need 550 more hospital beds in the next 10 years and capacity for over a million more GP appointments. Extra funding from the population increase will not cover this cost, and in any case it would be wasteful. We need to redesign services to help people stay well, reduce the need to use hospital services, and join up our services to make them more efficient.

There are always changes that will affect how our services operate. For instance, King George Hospital's emergency department is expected to close, which will mean an increase in demand at Whipps Cross and Newham hospitals.

Over the next 15 years, the population of Newham, Tower Hamlets and Waltham Forest will probably grow by 270,000

We need to improve the quality of care and patient experience

Existing challenges

On their own, these future problems would take great efforts to solve. But the NHS in our area is already facing other serious challenges.

Health and social care budgets are being squeezed. The spending freeze on NHS budgets, and spending cuts to local authority budgets, are placing great financial strain on services – in particular in areas of care where integrating health and social care is so important. Clinical Commissioning Group finances are currently in balance, but are predicted to worsen rapidly over the next five years. Barts Health already has the largest expected deficit of any trust in England (about £135 million for 2015/16).

We need to improve the quality of care and patient experience. There are problems about access to, and experience of, primary care and other services in the community. Around 40% of respondents to the GP National Patient Survey said they could not see a GP of their choice and over 30% found it difficult getting through on the phone. Some of our health services are world class, but too many are not. Barts Health is struggling to meet the London Quality Standards[4]. In June 2015 the Care Quality Commission assessed patient outcomes at Barts Health as being at, or better than, the national average in most medical and surgical wards at the hospital. But it also highlighted a lot of areas where improvements are needed. It rated the trust 'inadequate'[5]. In response, the trust published Safe and Compassionate[6], which describes how, by working with staff, patients and partners, it will deliver lasting improvements.

4 www.england.nhs.uk/london/our-work/quality-standards/
5 www.cqc.org.uk/provider/R1H
6 www.bartshealth.nhs.uk/media/286492/150915%20BH_Improvement_Plan_FINAL.pdf

■ **Our workforce is stretched**. We struggle to recruit and keep the staff we need. For example, a shortfall of more than 730 nurses (around 13% of the total) exists in East London NHS care providers. There is higher-than-average staff turnover[7] (some 2,800 staff leave our hospitals each year – about 15% of the total). Significant staff shortages exist in some critical specialist roles (such as in emergency medicine and paediatrics) and in primary and community care too – 40% of male GPs in Newham and Waltham Forest are nearing retirement age. We already spend too much on agency staff to plug the gaps.

We need to tackle the high costs of living, low staff morale in some places, and lack of clear training and development routes.

■ **We need to change the social culture of over-reliance on medical (and often emergency) services**. Life expectancy is worse than in the rest of England – environmental factors and deprivation are very important in this and need to be tackled. Supporting people to look after themselves, and better prevention of illness, would make the most significant difference to people's health. Yet we do not prioritise it. Persuading people to change is difficult, given the diversity and transient nature of the population, but it is possible.

■ **Our facilities and IT systems are not always set up to deliver high-quality or efficient care**. We have some of the most modern and high-tech facilities in the country – such as the new Royal London Hospital and the Sir Ludwig Guttmann Centre in Newham. However, many of our community facilities are under-used or unsuitably fitted out, too small, or in the wrong place for the services we need to give. We have many old buildings that need heavy investment just to maintain them – Whipps Cross needs over £80m of building investment.

Our IT systems are not fit for purpose. The equipment is poor. Some systems won't connect to each other. So greater efficiency and better services are held back.

What will happen if we allow things to continue as they are?

■ We'll need an extra 550 inpatient beds by 2025 (costing about £450 million to build and £250 million a year to run). Overall our organisations will be in deficit by almost £400 million by 2021/22. We won't be able to recruit the workforce to staff these beds, and we know that hospital is not the right place for many people[8].

■ Patient experience will decline and patient safety will be put at risk. People will face a confusing health system, and will need to wait longer for operations or travel outside the area for some planned care. People with a mental health illness will continue to be poorly treated compared to patients with a physical illness. Too many people will continue to die in hospital rather than in homely surroundings. Patients and staff will have to cope with poor environments. We won't be able to bring care close to home. We'll miss opportunities to raise morale in our workforce. And our finances will worsen[9].

We struggle to recruit and keep the staff we need

7 Compared with the Health Education North Central and East London area. HSCIC workforce statistics July 2015 www.hscic.gov.uk
8 Audits show that up to 40% of beds are occupied by people who do not need hospital care.
9 The Review of Operational Efficiency in NHS Providers (June 2015) suggested that the NHS could save £5 billion a year by making efficiencies in workforce and productivity; and improved medicines, estates and procurement management.

How we could create high-quality, safe and sustainable services

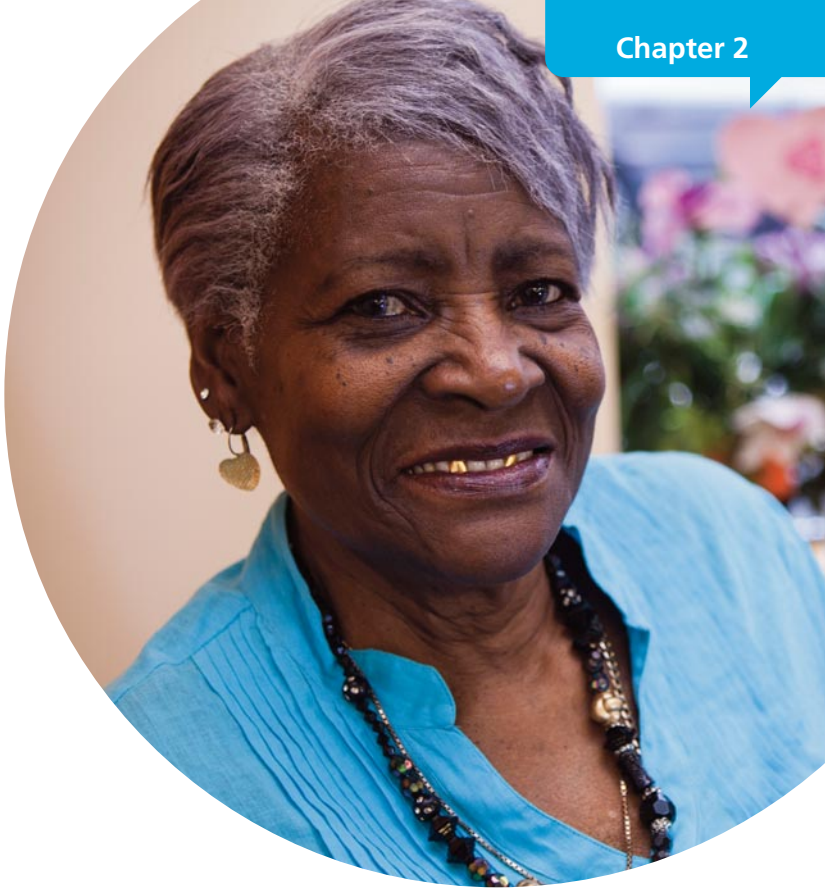
Our strategy

Our strategy aims to:

- support the **health and wellbeing** strategies of our boroughs, helping people to stay healthier and manage illness; and to access high-quality, appropriate care
- **change the culture** of how we commission and deliver care
- **increase involvement of patients and carers** in co-designing services and being part of shared decision-making
- **maximise the use of the assets** (for instance, buildings and the voluntary sector) in our communities
- commission activity to be in **fit-for-purpose care settings, often close to home**
- **focus some surgery in fewer locations** to improve patients' outcomes and experiences and increase efficiency
- acknowledge the importance of supporting people's **mental health** and well-being
- **ensure the system is flexible** enough to respond to changing demands
- help set our **finances on a path of sustainability.**

To meet these aims, we have created three 'clusters' – which are responsible for the overall delivery of the programme. Each cluster has developed specific initiatives that tackle important priorities for change.

Cluster	Initiatives
Care close to home	Improve access, capacity and coordination of primary care
	Expand **integrated care** to those at medium risk of hospital admission
	Put in place a more integrated urgent **care** model
	Improve **end-of-life care**
Strong sustainable hospitals	Establish **surgical hubs**
	Establish **acute care hubs** at each hospital
	Increase the proportion of **natural births**
Working across organisations	Reduce **unnecessary testing**
	Transform the **patient pathway and outpatients services**
	Develop a strategy for the future of **Mile End Hospital**
	Develop a strategy for the future of **Whipps Cross**
	Deliver **shared care records** across organisations
	Explore the opportunity that **physician associates** may bring



The initiatives are supported by work on organisational development, information technology, buildings and communications. Three important themes are built in to all the initiatives, namely:

- helping people manage their health better
- mental health
- children and young people.

Expected outcomes

If we deliver these initiatives through a coordinated, integrated plan over the next five years alongside productivity improvements, they will create the following results:

- A fairer service, treating the needs of everyone in society.
- A healthier population and patients who experience better care.
- More care being delivered close to home, in more efficient settings.
- A workforce that is more suited to providing efficient and effective modern healthcare – staff who better understand their role, who feel supported, and who are enthused about their job, healthcare and the NHS.
- Hospitals that can relieve the pressure on beds; can cope with the increase in population and long-term conditions; and can reduce waiting times or create new ways of raising income.
- Improvements in clinical quality. We expect these proposals to directly support the Safe and Compassionate improvement programme and the lifting of Barts Health out of special measures.
- Net savings from the Transforming Services Together programme of £104 million to £165 million over five years. From year five onwards, the annual saving will be £48 million. We aim to deliver the changes described in this summary, as well as internal cost improvement programmes (CIPs), and quality, innovation, productivity and prevention (QIPP) programmes. Probably this would leave some organisations in surplus and some in deficit. But there would be an overall balance in the local health economy.
- A significant drop in the need for capital funds. The Transforming Services Together programme proposes a budget for buildings and infrastructure of £72 million by 2021 (excluding essential estates and IT work). Without the programme, we would need £250 million.

Fixing the basics

Patients have told us that getting the basics right improves their clinical care and makes them happier. Patients want to be treated in well-maintained buildings. They don't want to tell their story to every member of staff they meet because our IT systems aren't joined up. They want staff to coordinate care, and to show empathy as well as being competent. They also want staff to understand that little things mean a lot, and above all to recognise that every person is different.

Our buildings

We need a flexible and fit-for-purpose estate. It will be actively managed and well used, and we'll take opportunities to share space with other services that benefit the public.

Primary and community care

The traditional model of small GP surgeries is no longer suitable. GP practices should cater for 10,000-15,000 patients or be on the same site as other practices or work as part of a network of practices. This would enable a greater range of primary and community care services to be provided in efficient and modern settings. Primary care hubs for over 30,000 patients should have on-site minor surgery units, sexual health clinics, a greater range of test facilities, and learning areas with access to nutritionists, health coaches and community groups.

Newham: The Vicarage Lane site in the north west would be a good place for a primary care hub. Other possible sites are the Sir Ludwig Guttmann Health Centre in Stratford; the Centre Manor Park; and two further hubs in Royal Docks ward and Canning Town.

Tower Hamlets: The hubs could be at St Andrew's Health Centre; Barkantine Centre; East One Health Centre; Blithehale Health Centre; and a further hub in Whitechapel.

Waltham Forest: Wood Street and Comely Bank could be a good location for a primary care hub. Other sites include St James Health Centre; around the adjoining Ainslie Therapy / Rehabilitation and Highams Court sites; Highams Hill; and Thorpe Combe Hospital.

Acute care[10]

Barts Health includes some of the most modern and efficient facilities in London, but also some of the worst. There are opportunities to improve many facilities, make better use of parts of the buildings and land and dispose of other parts that are inefficient.

St Bartholomew's Hospital: Complete the phased redevelopment of parts of the site; develop and preserve elements of the historic, heritage aspects.

Royal London Hospital: Increase the density (and therefore efficiency) of services in the building and improve the clinical co-location of services on the site; progress the sale and transfer of the old Royal London hospital to the London Borough of Tower Hamlets; and progress plans to develop two further plots of land into a life sciences specialist centre, in partnership with local education partners.

Mile End Hospital: There is an opportunity to consider more integration of acute, community, mental health and primary care services. A strategy is needed to define the most suitable use of the site.

10 Acute care is normally provided in hospital, where the patient requires 24/7 nursing under the care of a hospital consultant

Newham University Hospital: Develop the Gateway surgical centre on the site to allow more activity, in particular orthopaedic surgery.

Whipps Cross University Hospital: There is a continuing (and growing) demand for acute and emergency services on the site. We could work with local partners including the local authority and community based services to create a long-term strategy for the site.

Information Technology

The NHS collects vast amounts of data. We can use it much more intelligently. Developing joined-up information systems will support more effective, integrated healthcare.

We want people to experience services that are truly seamless, with clear signposting, co-ordination of care and exchange of information supporting every patient's journey. All clinicians should have access to important patient data when making decisions, thus reducing the risk of mistakes. We'll focus on ensuring that:

1. the infrastructure (computers, cables, services) is up to the job of supporting reliable, fast access to systems
2. wherever a patient is seen or a decision made in the health and care system, the appropriate data from every responsible health and care organisation is available safely in a real-time, easy-to-use way
3. we can combine data from every organisation to inform and prompt changes to treatments and care pathways
4. patients get access to their records so they can take control of their own health.

Our workforce

The limited labour supply in East London is further squeezed by high turnover and retirement rates. We struggle to recruit to important roles, such as nurses, social workers, allied health professionals and emergency consultants. With few incentives for key workers – such as affordable housing – rising costs are making local living impossible for many nurses and support staff. So we'll encourage the recruitment and retention of staff as follows:

- **Recruitment**. We'll work with universities and other education providers to offer courses to qualify in new roles, e.g. physician associates[11] and advanced nurse practitioners. We'll encourage young people to work in the NHS by connecting with local schools and other education providers. We'll develop apprenticeships and internships. We'll market the attractiveness of working in the NHS in East London.

- **Retention**. We'll help with this through training and development opportunities, flexible working options and financial incentives. These could include 'golden hellos' or 'golden handcuffs'; support with the high cost of London living and transport; key-worker housing; bursaries or student loans to help fill hard-to-fill vacancies. We'll also see if we can remove incentives to leave, such as the high amounts we pay for bank and agency staff.

Joined-up working is also needed in the community, with GPs, pharmacies, dental, community health and social care services (all connected by IT systems) working together to provide an integrated urgent-care response, closer to where people live.

11 Physician associates, though not doctors, must have a science degree and a two-year postgraduate diploma. They can perform a large part of a doctor's tasks at a reduced cost – meaning doctors can focus on the patients and illnesses that need their skills.

Our detailed proposals

Preventing ill health

Life (and healthy life) expectancy is shorter in East London than in the rest of the country. We aim to change the existing culture of over-reliance on medical/hospital services to one where prevention of ill health gets greater priority, and people take more responsibility for their own health. However, this cannot be done by health services alone. The NHS must work with a range of organisations, including those in social care and the voluntary sector to:

- support people to live healthier lives
- make our schools and workplaces healthier
- identify ill health earlier – for instance through screening programmes.

Doing this would mean a healthier population. People would have a better quality of life. They would visit emergency departments and be admitted to hospital less often. We'd be able to provide more supportive care. And we'd have healthier staff working under less pressure.

> Over the next five years the NHS will invest more in primary care

Providing care close to home

GPs with a registered list of patients are the bedrock of NHS care and will remain so. Over the next five years the NHS will invest more in primary care. The number of GPs in training needs to rise as fast as possible, and we need to provide new ways of encouraging them to stay.

We need to integrate emergency and ambulance care, GP out-of-hours services, urgent-care centres and NHS 111 so that people can get the right care in the right place at the right time.

Too many people go into hospital or stay in hospital longer than necessary. Early, co-ordinated support that focuses on their wellbeing as well as their health and social care can reduce their dependency on services in the long run. It can also ensure they are admitted to hospital only when it's really needed. This means we need new partnerships with local authorities, communities and employers. And we need to act decisively to break down barriers between GPs and hospitals, physical and mental health services, and health and social care.

New integrated providers will enable the NHS to take a more rounded view of patient care. We're also committed to developing new payment schemes that support providers to work better together to create innovative solutions to local problems.

Making these changes could significantly improve health, reduce health inequalities, improve patient experiences, and create a more efficient service. It could also enable the NHS to cope with the expected rise in attendance at hospitals, GP surgeries etc. Here are some other changes that will help:

- Some activity in GP surgeries could be provided in pharmacies and by supporting self-care.
- Around 180,000 outpatient appointments a year could be provided in other ways that patients would find more convenient.
- The 92,000 extra attendances that are expected at Barts Health emergency departments a year (by 2020) could be managed by shifting activity to primary care and improving patient pathways and system efficiencies.

To provide care close to home, we have prioritised several important initiatives:

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Primary care There is an increasing (and ageing) population, a rising burden of disease and a shortage of GPs. Patients find access and quality of care unsatisfactory. The population has some of the poorest public health outcomes in the country (for example, survival of cancers and cardiovascular disease, and life expectancy).	Improve access to general practice, pharmacies, dentists and optometrists, for instance by providing supportive online tools or Skype appointments. Establish proactive care by: • empowering patients to take more control of their health, and • offering wellbeing inductions for new patients. Coordinating care. We will make sure 20% of appointments are longer, to suit the needs of patients with complex conditions. And we will continue to connect our IT systems to each other. We believe co-ordinated, proactive, accessible primary care can be given only by a broader range of professionals (for example, by creating physician associate roles or by having pharmacists working alongside GPs) in: - primary care practices serving over 10,000 patients - smaller practices working together in collaborative provider networks that serve at least 10,000 patients, or on a shared primary care site 'a hub'.	The whole population will be healthier. People will find appointments are more convenient, so minor ill health can be resolved quickly and easily. More services will be available in the community, often in the same building, so patients will have less need to go to hospital. We'll have more primary care staff. Patients will be more able to choose a female or male GP. We'll reduce patient complaints by 50%.
Integrated care Too many people go into hospital or stay there longer than necessary.	Integrated care gives co-ordinated health and social care in patients' own homes or in the community to help them stay well or manage their illness. We want to improve our services and extend integrated care to people at moderate risk of going into hospital (today it's available only to those at high risk of it).	People with moderate risk of going into hospital will manage their health better, stay well, be able to live in their own home or the community (rather than have long spells in hospital) and reduce their reliance on urgent care services.

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Urgent care People find it difficult and confusing to access urgent care – so they often end up going to emergency departments or calling an ambulance, which diverts attention from people with more serious and life-threatening problems.	Simplify and integrate urgent care by: - developing a simple online directory of services - integrating NHS 111 with the urgent-care system so there is one place where people can get advice or book urgent appointments at a primary care hub, their GP or other providers - replacing standalone walk-in centres with primary care hubs that will provide a greater range of services. Provide more urgent-care appointments in the community, including in the evenings and at weekends. Provide a more comprehensive service in urgent-care centres at the front door of emergency departments.	Patients will get the care they need in a timely, easily understood and convenient way. This will help them return to health without needing to visit an emergency department. Around one in four patients attending an emergency department will be treated in an urgent-care setting, meaning emergency departments will be better able to give the best possible care to those most in need.
End-of-life care One in three people admitted as emergencies to a hospital are receiving end-of-life care. However, most people would prefer to die in the place that they usually live.	Identify earlier the need for end-of-life care. Have supported conversations with patients. Have better recording and sharing of patients' preferences and care plans. More community-based end-of-life services with 24/7 access Better partnership working across the health, social care and voluntary sector – including making more use of community facilities such as hospices.	People will be able to make better choices about their end-of-life care and their experience of end of life will improve. A 30% reduction in use of hospital beds during the last year of life. Half the number of emergency hospital admissions for people at the end of their life.

Strong, sustainable hospitals

We will focus on helping people stay fit and healthy and providing care close to home. But we need to ensure that when people fall seriously ill or need emergency care, local hospitals will provide strong, safe, high-quality and sustainable services.

Some of our proposals are relatively small and will cost nothing. Others need organisations, staff and the public to work together.

To provide high-quality local care, we'll need to keep the existing emergency departments and maternity units. But to cope with the expected extra activity, we'll need to change the way we work, as follows:

Improved local care with specialisation if this improves outcomes and provides safer care

To provide care effectively for the growing populations, we need to ensure Newham and Whipps Cross can provide high-quality care for the vast majority of conditions likely to occur locally.

We also need the Royal London to work effectively to serve its local community and a wider population in its role as a specialist centre. This doesn't really happen now as the site is often too busy treating emergency and very unwell patients to cater for the day-to-day needs of local people. This results in large amounts of planned surgery being cancelled and patients staying in hospital longer than they should, affecting local people and patients who have been transferred from further away.

More integration with community and social care

Our hospitals need to be better integrated with the community as well as forming stronger partnerships with charitable and voluntary organisations. We need to ensure local services run as effectively as possible alongside other clinical teams both on and off the hospital sites.

Working in networks across our sites and more widely

We need to be far better at organising and simplifying our acute and emergency care system and network arrangements. Our proposals will achieve this, standardising and improving the system and the standards of care.

The three main acute sites do not consistently meet London quality standards. For example, we know that only the Royal London site offers access to emergency interventional radiology in under an hour. Our approach outlines where we need to look across sites and in some cases change the arrangements for life- or limb-saving specialist services.

Pictured: Newham Gateway Surgical Centre

We have prioritised several key initiatives to develop strong, sustainable hospitals:

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Acute care hubs Too many people are admitted to a hospital ward as this is the only way they can get rapid medical specialist opinion and tests. This means patients who do not need 24/7 nursing care sometimes stay in hospital unnecessarily.	Bring together the clinical areas of the hospital that focus on initial assessment, rapid treatment and recovery at each site to work as 'acute care hubs'. This would mean the majority of patients being treated without being admitted. We'd admit to a specialist ward only patients needing 24/7 nursing/medical care.	Fewer patients will need a hospital bed – avoiding unnecessary stays in hospital and avoiding the need to build more hospital capacity. More emergency consultant cover and quicker treatment. Improved care for adults, young people and children with physical or mental health problems.
Maternity – increase the proportion of natural births Over the next 10 years the number of births will increase – thousands more every year. Women report some of the worst experiences of care in London. Too many women don't have real choice of where they have their baby – often giving birth in an obstetric-led ward that puts them at higher risk of interventions and operations compared with planned midwife-led births.	Introduce new ways of working that provide more informed choice and promote more natural delivery. We want women to have real continuity of care so they are supported throughout their pregnancy and can have a more natural birth in midwife-led settings.	Women will feel better supported through their pregnancy with an improved experience of care. We'll give better, safer care and make fewer unnecessary interventions. A third of women will choose a midwifery-led birth rather than an obstetric-led birth. We'll be able to care for women and their babies without having to build more hospital capacity.
Surgical hubs The quality of surgery could be improved. Too many people stay longer in hospital than necessary. A lack of coordination means planned surgery sometimes affects emergency surgery and vice versa. Many patients are waiting far too long for operations.	Create surgery centres of excellence ('hubs'). Newham, Royal London and Whipps Cross would each specialise in a number of specialties. This would: - reduce waiting times and the number of patients having to go outside East London for surgery - improve emergency and planned surgery - reduce the number of cancelled operations. New pre-operative pathways will deliver care as locally as possible and focus on recovery and long-term health improvement.	A better quality of care. Better use of specialist equipment and staff; shorter waiting times for patients; and fewer cancelled operations. Better patient experience – for example, a 10% reduction in length of stay for planned admissions. Better efficiency – for example, operating-theatre use improved by around 12%. Proper support for emergency and maternity services and less-complex surgery at each of the three hospitals.

Investing in children's health is investing in the future. A good, healthy start in life is essential if we are to increase life expectancy

Working across organisations to continually improve care

Many of our initiatives will need organisations to work together closer than ever. For example, clinicians from primary, community and secondary care organisations need to work together to agree pathways that speed up patients' diagnosis and treatment. We also need to work together to increase the number of physician associates, and to define strategies for the future of Mile End Hospital and Whipps Cross Hospital.

Two themes are weaved through all our initiatives:

Mental health

- A quarter of the population will suffer from a mental health problem at some point in their lives.
- Three quarters of people with mental health problems never get treatment.
- On average, people with serious mental health illnesses die 20 years earlier than people without them.

We'll prioritise improving services for expectant mothers and their partners; children and adolescents; people in crisis; and people with dementia. While doing so, we'll review the whole mental health system and develop a five-year strategy.

Children and young people

Investing in children's health is investing in the future. A good, healthy start in life is essential if we are to increase life expectancy and the number of healthy years people live. We need to get better at:

- co-ordinating services and joint working. Young people needing healthcare are getting passed between too many people and organisations
- identifying when a child or young person's conditions could be better and more quickly treated in a community setting. There are too many referrals to hospitals
- supporting children and their parents/carers to self-care, and to access services when necessary.

We'll involve children and young people in designing and commissioning services. We'll work with schools, children's centres and youth services, which are vital settings for improving health. And we'll improve the way young people move into adult services.

We'll redesign children's mental health services to make them less fragmented. We'll work with schools to make sure mental health problems are identified earlier so that young people get the support they need more quickly.

We have prioritised several key initiatives to improve health in East London:

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Transform the patient pathway and outpatients We are struggling to manage the number of outpatient appointments. However: - up to 20% of referrals to hospitals are not needed - up to 20% of patients do not attend their appointments - the referral process is complicated - the way follow-up appointments are arranged can be ineffective – there are often better ways for patients to access specialist advice - we don't always help patients to manage their own conditions.	Redesign the patient pathways for some of the most common: • long-term conditions (for example cardiovascular disease, respiratory disease and type 2 diabetes) • planned care services (for example musculo-skeletal and dermatology). Make better use of technology. Develop new processes for outpatient treatment and follow-up and improve referral processes so that when they need specialist advice, patients get the care they need as quickly as possible.	There will be a 20% drop in hospital-based outpatient appointments as unnecessary ones are not made and other methods are developed, for example using phone, email and Skype clinics. Patients will find the system easier to navigate and be better cared for closer to their home.
Reduce unnecessary testing About a quarter of tests on patients aren't needed. Some East London GPs order over 50% more high-cost tests than other GPs. This wastes resources, delays the diagnosis and treatment of patients who need tests, and subjects people to unnecessary inconvenience and worry.	Standardise processes and reduce unnecessary testing in the community and in hospitals. Consider enabling GPs to refer straight to tests in hospitals (rather than having to wait to see a hospital specialist first). Improve IT to share test results between GPs and hospitals, so tests aren't repeated.	Patients won't have to attend (and be subjected to) unnecessary tests and appointments. By 2020/21, there will be a 20% drop in spending on the top 20 most costly GP-generated tests.
Shared care records There has been significant progress in sharing patient records but there is still: - a lack of connectivity between all care providers - a need for a more comprehensive system, for example being able to book services through the system, and everyone being able to add information (not just 'read only') - a need to make access intuitive and simple, and to make records up to date and accurate, otherwise health and social care staff will not use them.	Better understand what needs to be shared and how it can be made accessible, secure and useful to staff who need it and to patients. Increase the use of shared records. Increase the amount of information available. Increase the number of staff in health and social care organisations who can access shared records. Work with patients to gain their support and consent to view their records.	Our shared care record infrastructure will be in place. There will be quicker, more coordinated care. Patients will not have to keep repeating their story and will be better able to self-care or receive care in their own home. Staff will be able to provide better care as they will better understand the patient's history. We'll get more efficient as we reduce our reliance on paper.

Initiatives and the case for change	What we propose	What we'll deliver within the next five years
Physician associates The area needs an extra 125 GPs in five years and almost 200 in ten years – but there is already a national shortage of GPs. Physician associates can perform a large proportion of a doctor's tasks at a reduced cost – meaning doctors can focus on the patients and illnesses that need their skills.	As well as developing different ways of working and effective ways of recruiting and keeping staff, we'll use more physician associates.	We'll have developed the role of physician associate. GPs and other clinicians can spend their time giving high-quality healthcare. Staff skills will be better suited to their jobs and patients' needs. This will breathe new life into the workforce, improving staff satisfaction and motivation. Patients will get faster, more effective services.
Mile End hospital The Mile End site offers a range of services from different providers. Barts Health has two acute inpatient wards, but these are separate from the rest of the Royal London site. This makes it hard for them to provide high-quality care, as well as making them hard to manage.	We'll continue to provide acute mental health services at Mile End but will seek to change other inpatient services. Barts and the local health economy should develop a longer-term strategy for the site, which could include more facilities that are less intensive than being treated in a hospital but more intensive than services offered in the community, mental health or community service facilities, or the sale of underused parts of the site for educational or residential use.	A health economy strategy to define the long-term future for the site. Improved efficiency, for instance shorter travel times for clinicians and better sharing of facilities. Improved outcomes and patient satisfaction, as clinicians will better understand their patients' needs, and will be able to discharge patients in a timely manner.
Whipps Cross hospital - The buildings need about £80million just to keep them safe and meeting minimum requirements. - The buildings are not designed to provide modern healthcare. For instance, the maternity unit is not connected to the main site, so emergencies need an ambulance to transport mothers and babies. - Whipps Cross has one of the largest sites in London but is used very inefficiently. It is a wasted resource.	We'll work with partners across health and social care to develop a robust strategy for the site's long-term future.	We'll set out a clear strategy, defining the site's long-term future; we'll decide how the transformation will be done; and we'll get started on making the changes we need.

Finance and sustainability

Net running costs and savings

(five years, upper and lower estimates for the 13 initiatives)

	Upper £m	Lower £m
Care close to home		
Primary care	34.5	30.7
Urgent care	5.8	2.5
Integrated care	6.6	4.2
End of life care	3.4	1.6
	50.3	39.0
Strong sustainable hospitals		
Acute care hubs	35.7	22.6
Surgical hubs incl. Interventional Radiology	4.3	0.0
Normalising births	(13.8)	(14.1)
	26.3	8.6
Cross-cutting themes		
Pathway redesign	82.4	64.9
Reduce unnecessary testing	25.5	20.7
Shared care records	(11.1)	(12.3)
Physician associates	(3.2)	(11.5)
Mile End hospital	-	-
Whipps Cross hospital	(5.1)	(5.1)
	88.4	56.8
Net TST programme savings	164.9	104.4

* Figures in blue are investments

By year five the saving is £48 million per year

Transforming Services Together initiatives will go a long way towards solving the big strategic challenges we face

Capital costs

We have also included the expected capital cost to the local health system if the TST programme isn't implemented and we have to build a new 550-bed hospital instead.

Capital funding sources to rebuild Whipps Cross Hospital require further thinking and could include bidding for national funds or selling assets and would include a reduction in Barts Health backlog maintenance.

	5 years 2016 to 2021 (£m)		10 years 2016 to 2025 (£m)	
	WITHOUT the TST programme	**WITH** the TST programme	**WITHOUT** the TST programme	**WITH** the TST programme
Minimum costs of essential IT and estates works in primary care and at Barts Health	102	102	152	152
Cost of redesign and complete rebuild of Whipps Cross (to retain existing 600 beds)	41	41	453	453
Costs of building new hospital and primary care facilities (including an extra 550 beds)	174		471	
Capital costs of implementing TST programme		31		31
Costs of land for a new hospital site	35		35	
Capital costs	**352**	**174**	**1,111**	**636**

The local health economy

Transforming Services Together initiatives will go a long way towards solving the big strategic challenges we face. But several other initiatives need to be delivered in partnership if we are to transform the health of our population and the health and social care system.

For instance:

- better prevention of illness – this needs to happen in partnership with local authorities and Public Health England
- other savings – even if the health and social care economy can achieve the improvements and efficiencies detailed here, by 2021 there will still be an historic deficit that will need external investment, as will any rebuilding at Whipps Cross
- changes to other health and social care services, for example specialist services.

Next steps

Success in these initiatives will depend on continuing the strong working relationships we have developed over the past year with all key partners.

Our greatest challenge is how we develop the enthusiasm, collective responsibility, and (once they are finalised) clear, achievable plans, to implement the solutions that we know people need. From February to May 2016 we will:

- engage with staff, stakeholders, patients and the public to test these proposals
- further develop our ideas
- develop implementation plans with a phased and prioritised programme of change. This will include working on the links between these proposals and the Care Quality Commission's improvement plan at Barts Health; between the different workstreams, including IT, estates and workforce; and between the different funding mechanisms/incentives
- assess the impact of our proposals on travel, the environment and equalities
- strengthen the leadership and capability to support the next phase of the programme
- agree how we can measure, monitor and support progress towards the objectives.

We know some of our proposals may have to change, and that external pressures will require new thinking. It is certain that not every proposal will be fulfilled in the way we describe. The strategy will need to be continually monitored and reviewed as challenges and opportunities present themselves. However, we are clear that not taking action now would be catastrophic for the health economy. We believe that the strategy sets the health economy on a path to deliver the changes we need to achieve clinical and financial sustainability, and better health for the population we serve.

We believe that the strategy sets the health economy on a path to deliver the changes we need to achieve clinical and financial sustainability, and better health for the population we serve

Questionnaire

Please fill in this questionnaire online at **www.transformingservices.org.uk** or fill it in here and post to: **TST, 5th Floor, Clifton House, 75-77 Worship Street, London EC2A 2DU**

We welcome your comments on any aspect of our proposals. However, you may wish to think particularly about:

1 Our strategy	**Prompts**: Have we correctly set out the challenges? Is our overall strategy right? Are there issues we have not addressed well enough or at all?
2 Our investment case	**Prompts**: We plan to spend about £140 million over the next five years. We think this will help us meet the challenge of population growth and growing demand, make significant improvements and save the NHS around £300 million. Is this the right level of investment? Should we be more or less ambitious? Are our proposals achievable? Are any of them unnecessary?
3 The 13 high-impact initiatives	**Prompts**: Will these initiatives focus on the biggest challenges or on where they will make the biggest improvements? What issues should we bear in mind if we take them forward in their current format?
4 Do you have any other comments?	

About you

We would find it useful if you could answer the questions below so we can see the type of people who are responding and whether different groups think differently about the proposals. We also want to know if any groups are not represented in our engagement.

Name: _____

You don't have to give us your name if you don't want to and we will still take your views into account.

Would you like to be kept up to date with information about this engagement?

☐ Yes ☐ No

If yes, please give us your email or postal address _____

_____

Gender:

☐ Male ☐ Female ☐ Other ☐ Prefer not to say

How old are you?

☐ Under 16 ☐ 16-25 ☐ 26-40 ☐ 41-65 ☐ 66-74 ☐ 75 or over ☐ Prefer not to say

Do you consider yourself to have a disability?

☐ Yes ☐ No ☐ Prefer not to say

Do you identify as:

☐ Heterosexual ☐ Homosexual ☐ Other ☐ Prefer not to say

What is your ethnic background?

White:

☐ White British ☐ White Irish ☐ Any other white background

Mixed:

☐ White and Black African ☐ White and Black Caribbean ☐ White and Asian

☐ Any other mixed background

Asian:

☐ Asian British ☐ Indian Bangladeshi ☐ Pakistani ☐ Chinese

☐ Any other Asian background

Black:

☐ Black British ☐ Black African ☐ Black Caribbean ☐ Any other Black background

☐ Any other ethnic group ☐ Prefer not to say

Which belief or religion, if any, do you most identify with?

☐ Agnosticism ☐ Atheism ☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Islam

☐ Judaism ☐ Sikhism ☐ Other ☐ Prefer not to say

Thank you for your time. Your help will make a difference.

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TST overarching communications and engagement strategy and plan

(Approved at TST, CCG and Barts Health Boards in Jan/Feb 2016)

January to May 2016

Contents

1. Aims and objectives

This communications and engagement plan sets out how Newham, Tower Hamlets, Waltham Forest and neighbouring CCGs, supported by NEL CSU and working with Barts Health NHS Trust, other providers, local authorities and NHS England aim to engage and communicate effectively with patients, the public and relevant stakeholders about transforming healthcare services in east London. Engagement activities will involve local people and stakeholders, particularly those likely to have an interest in these services so that:

- Staff, patients, the public and stakeholders:
    - have the opportunity to make their views known
    - are clear about any proposed changes
    - are positive about the changes
    - are not unnecessarily worried about the changes
    - can ‘sign up to’ engaging in the future
- The CCGs meet their legal/statutory obligations.

We want meaningful engagement with local people and other stakeholders. We will know that we have achieved this if people:

- feel informed and listened to
- have given their views
- provide feedback that improves the development of the service
- support the changes.

All communications and engagement will be planned, clear and informative so that stakeholders are reassured and their needs are managed.

2. Statutory responsibilities

Newham, Tower Hamlets and Waltham Forest CCGs (the CCGs) have been responsible for engaging with stakeholders to ensure their views help shape any changes.

The CCGs are also responsible for ensuring that public involvement is carried out properly (as outlined in section 14Z2 of The NHS Act 2006, as amended). NHS England's guidance: *Planning and delivering service changes for patients* (December 2013) is also relevant.

The CCGs will be supported by NEL CSU to plan and deliver:

- **Phase one:** Communications and engagement activities in the period following the publication of the Strategy and Investment Case (SIC) including analysis of feedback from engagement
- **Phase two:** Any required consultation(s) on significant changes arising from the SIC. This will potentially be based on proposals for significant surgery changes, Whipps Cross and Mile End hospitals later in 2016 or in 2017.

The CCGs' governing bodies are responsible for decision-making regarding the engagement.

3. Challenges and opportunities

The key communications challenges, opportunities and risks include:

Challenge / opportunity / risk	Proposed plan
• **Engage staff** in this transformational change – some may see this as another reorganisation, when many of them are already de-motivated (see CQC report).	• Clear internal communication and engagement of leaders and change leaders. • Work with the OD programme and Barts Health. Aim for similar integration and alignment in primary care, integrated care etc.
• Ensure the engagement provides the partners with the **legal authority** to make changes when consultation is not required.	• Develop a clear communications action plan, agree with key partners; ensure communications is seen as central and critical to the success of the programme and aligned with workstreams. • Discuss with the inner north east London Joint Overview and Scrutiny Committee (JOSC) and the outer north east London JOSC so there is a unified scrutiny arrangement and/or a unified view.
• **Ensure changes are not viewed as downgrading by managing public perceptions but are seen as positively taking the NHS forward.**	• Ensure proposals are discussed and agreed by staff (who have considerable influence on public opinion) and Boards • Build trust in the NHS; putting clinicians

	(especially) and managers in front of the public to explain the proposals • Build on the relationships we have in place with our local NHS (members of the Transforming Services Together programme meet regularly with CCG, Barts Health and other colleagues). • Develop lines to describe the benefits for each hospital (and the group of hospitals). Whilst this is a strategic plan, we cannot ignore the fact that the public are interested in *their* local hospital.
• **Positively engage with the section of public and stakeholders** who are negatively predisposed as they have: o seen reconfigurations (Fit for the Future, Health for NEL) leading to consultation fatigue and lack of belief that things will change o seen criticism of existing NHS services (e.g. CQC reports – so they lack trust in the NHS to make good decisions/changes) o fixed views on finances, PFI, privatisation etc (e.g. 38 degrees, Save our NHS).	• Build leadership and change leaders. • Make it clear how change is (and must be) continuous and that proposals build on previous (successful) work. • Explain that TST is part of the solution to the problems. • Recognise failings where they are clear but correct inaccurate criticism. • Brief stakeholders and ensure we understand their aims / objectives. How do we give them what they want? • Recognise that some critics will not change their mind. But we should not distance them from the programme, rather we need to listen to the issues to take them into consideration, amend our plans if necessary, and build a community of supporters around them.
• Manage the **political sensitivities.** E.g. ensure that any proposals are not used as a political football – particularly given the London elections in May.	• It is essential that we engage on the issues and options that are possible. Including all stakeholders in the planning process.

4. Key messages – case for change

We want to make a difference in east London and:

- address inequalities. Many of our residents receive excellent care, but the quality and availability of some of our services could be improved. The health of some of our residents is poor, with life expectancy in some parts of east London significantly lower than the England average.
- help patients to be in control of their own health and lead longer, healthier lives.

We have a huge challenge in east London and must plan ahead to address it.

- Our population is growing and in 15 years it is estimated we will have an additional 270,000 residents – equivalent to another London borough or a city the size of Southampton. If we carry on as we are, the East London organisations will be around £400 million in debt and would need a further 550 hospital beds – the equivalent to another hospital. This would be unaffordable to build and run.
- When we published our Case for Change in July 2014, we said that emergency and maternity services would be retained on each of the three main Barts Health sites. Since that time we have established that we face the opposite challenge. We need to maintain these services on each site, and cope with the anticipated increase in healthcare needs – but without having to build a new hospital.
- Health and social care budgets are being squeezed.
- We are struggling to recruit and retain the numbers of staff we need while many staff, particularly in primary care are nearing or past retirement age.
- Some of our buildings and IT are not fit for purpose – Whipps Cross needs more than £80 million of capital investment as a minimum. Much of the primary care estate is also unsuitable for the safe delivery of healthcare.
- CCG finances are currently in balance, but Barts has the largest deficit in the NHS.

This is not the start of the process; there is lots of work already underway to improve healthcare services

- Improvements put in place at Barts Health mean it has one of the lowest mortality rates in the UK (4th lowest). For example, performance in stroke and major trauma care are exceptional - these changes are saving lives.
- Over the past three years, £21 million has been invested in the Whipps Cross estate and we have some of the most modern and high-tech facilities e.g. the Sir Ludwig Guttmann Health & Wellbeing Centre or The Centre (Manor Park) in Newham.
- Integrated care is being provided to thousands of residents across east London, putting them more in control of their health and reducing admissions to hospital
- Our IT systems are getting better and more connected. For example, more hospital clinicians in Barts Health are able to see primary health records, and vice versa, resulting in a quicker and more streamlined service for patients.

5. Key messages – our proposals

The TST programme offers the opportunity to develop solutions:

- locally where necessary (but sharing learning and resources)
- in partnership with different organisations
- once across the three boroughs, where it is efficient and effective to do so.

Taken together, the changes would transform health and care in East London. In particular we need to focus on changing the social culture of over-reliance on medical services.

Care closer to home

- More **integrated care** for more people at risk of going into hospital, so that they can be cared for at home and stay out of hospital.
- A simplified and integrated **urgent care** system, so that people don't always turn up to emergency departments. We need to integrate NHS 111 with the urgent care system so patients can get advice, get a prescription, book an urgent or planned appointment with their GP – a one stop shop.
- Earlier identification of the need for **end of life care**, supported conversations and recording and sharing preferences. To enable this there needs to be shared care plans and enhanced community and palliative services delivered by better partnership working across the health, social care and voluntary sector.
- Making **primary care** more accessible; more proactive – helping people to take control of their own health and to be healthier; and more coordinated (with joined up IT systems so that care givers can provide better, quicker advice and services often in the same building). To do this we need fewer smaller GP practices. GP practices in the future should have list sizes over 10,000, or if they are smaller, work together in integrated provider networks, or on the same site as other practices.

Strong sustainable hospitals

We need three strong and sustainable hospitals providing emergency and acute care for our growing populations. Each needs a well-functioning emergency department and in the future, they will need to work more closely together and provide different services. We need to address the belief that having all services at a local hospital is a necessary 'security blanket'.

- Develop **surgery centres of excellence (surgical hubs)** at each of Newham hospital, Whipps Cross hospital and The Royal London. This would a) support the viability of these hospitals b) release capacity at Royal London, which is over-capacity c) provide a better patient experience (and outcomes), reducing cancellations and waiting times. Pre-operative and post-operative care would be at the patient's local hospital.
- Develop **acute care hubs** at each hospital site (Newham, Whipps Cross and The Royal London), bringing together more specialists and test facilities to the front door of hospitals so that patients can be diagnosed and treated more quickly and fewer patients will need to be admitted to a hospital ward.

- Provide more choice and continuity of care to **increase the proportion of natural births** (for instance in midwife-led settings). This will help us to cope with the expected 5,000 more births a year across north east London in the next 10 years.

Working across organisations

- Reduce the number of hospital-based **outpatient appointments** by improving the quality of referrals and improving Skype, telephone and other access.
- **Reduce unnecessary testing and sharing care records.** Consider GPs being able to directly refer patients for hospital tests (rather than to a hospital consultant who then does the referral) and at the same time, investigate why some GPs refer far more people for high-cost tests than other GPs.
- Develop new roles, different ways of working and effective ways of recruiting and retaining staff. For example, we will **introduce more physician associates**, health coaches and other roles who will be able to take on much of the day to day work of a GP. This will free up GPs (who are in short supply) to concentrate their expertise where it is needed most.
- Develop a strategy for making better use of **Mile End Hospital**. This could include more step-up/step-down facilities, mental health or community service facilities or even sale of underused parts of the site for educational or residential use
- Develop a strategy with partners, for the long-term future of **Whipps Cross.**
- We must improve the health, life expectancy and **care of people with mental health difficulties**, particularly focusing on rapid treatment early in life when the majority of symptoms first appear.
- We will work with schools, children's centres and youth services which are vital settings for improving the **health of young people**; and we will improve the way young people transition into adult services. We will redesign children's mental health services to make them less fragmented and work with schools to make sure mental health problems are identified earlier, leading to young people getting the support they need more quickly.

The expected outcomes

The combined impact of these initiatives, if they are all delivered through a coordinated, integrated delivery plan over the next five years, alongside productivity improvements, will be:

- a significant increase in activity being delivered closer to home, in more efficient care settings
- a healthier population, and patients who experience better care
- a workforce that is more appropriate for delivery of efficient and effective modern healthcare; staff who better understand their role, who feel supported and who are enthused about their job, healthcare and the NHS
- that hospitals are able to relieve the existing pressure on beds; can cope with the increase in population and long term conditions; and help to reduce waiting times, or create opportunities for new income streams
- improvements in the clinical quality of services and the physical and mental health of the whole population. We expect these proposals to directly support the Safe and

Compassionate improvement programme and the transition of Barts Health out of special measures

- net savings from the TST programme of between £104 million and £165 million over five years to 2020/21. The expected annual recurrent net saving by 2020/21 is £48 million. The most likely position if we deliver the changes described in this document; internal cost improvement programmes (CIPs); and quality, innovation, productivity and prevention (QIPP) programmes, is one of overall health economy balance with some organisations being in surplus and some in deficit.
- a significant reduction in the capital spend required. The TST programme proposes a budget for buildings and infrastructure of £72 million by 2021 (excluding essential estates and IT works), but the requirement if TST is not put into action is £250 million.

TST key messages on a page

Transforming Services Together is a joint agreement between Clinical Commissioning Groups (CCGs) in Newham, Tower Hamlets and Waltham Forest and our main local hospital trust Barts Health, to invest over £100 million in new health services and buildings over the next five years

1. We need to help people take responsibility for their own health, managing their health and illnesses better and to use health services appropriately
2. We are expecting 270,000 more people in our three boroughs. People will live longer. Drugs and treatments will get more expensive. We already struggle to recruit staff.
3. We need to strengthen our three main hospitals (Royal London, Whipps Cross and Newham). For instance, centres of excellence on each site will improve surgery. Acute hubs will reduce the number of people unnecessarily admitted to hospital and reduce the time patients are in hospital. Both these initiatives will strengthen the existing A&Es and maternity units
4. We will develop joined up services closer to people's homes. For instance, we will improve our sharing of records between different parts of the NHS, integrate care between different organisations and reduce unnecessary testing. There will be fewer small GP practices or they will work in networks or on sites with other practices so that they can offer better access, more services to help people manage their health better and to reduce costs.
5. We will work together to: develop services and plans for developing Whipps Cross and Mile End hospitals; develop new roles to meet the workforce challenges together (e.g. physician associates); and develop our IT
6. Our plan aims to save around £300 million over five years and around £800 million over ten years

These services will need to benefit the whole community, reduce health inequalities and address mental health, as well as physical health problems.

NHS

Our strategy

Our strategy aims to:

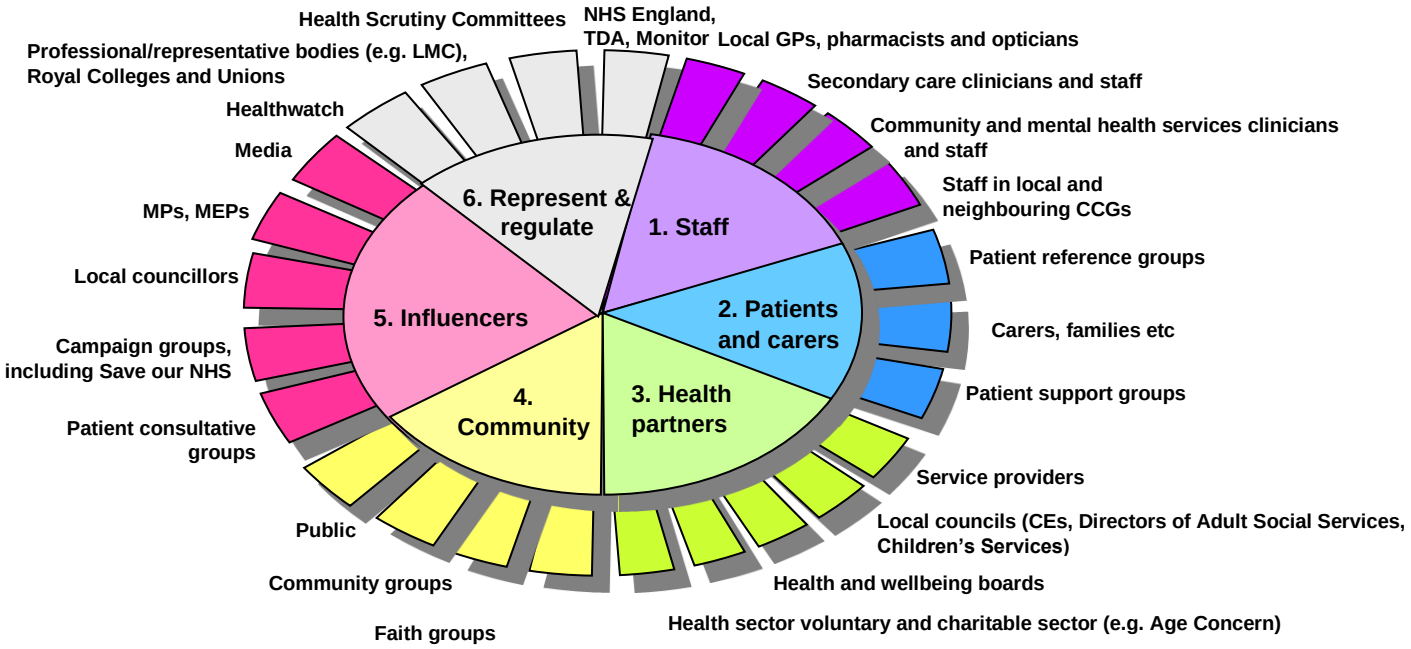
- embrace and support the health and wellbeing strategies of each borough;
- promote health and well-being by developing the knowledge, skills and confidence to self-manage through collaborative care and support planning
- change the culture of how we commission and deliver care and support a learning healthcare system
- increase involvement of patients and carers in co-production and decision-making
- maximise the use of the significant assets in our communities and voluntary sectors
- commission services in fit-for-purpose settings of care, often closer to home

- help people to stay healthier and manage illnesses; to access high quality, appropriate care earlier and more easily
- focus some specialisms in fewer locations to improve patient outcomes and experiences and drive up efficiencies
- value the importance of continuity and therapeutic relationships, acknowledging the importance of supporting people's mental health and well-being needs
- ensure the system can respond to the changing demands on our services that we have predicted as part of our *Case for Change*
- help set our finances on a path of sustainability in a challenging environment.

6. Stakeholders

There are a number of people and organisations who/which are involved, or interested in proposed changes to healthcare services in east London. They key external and internal audiences include:

- NHS England
- Neighbouring CCGs - in particular, City and Hackney, Barking and Dagenham, Havering, Redbridge and where appropriate, north central London CCGs
- NEL Commissioning Support Unit
- Homerton University Hospital NHS Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Third sector organisations
- Local authorities and public health teams; City of London; London boroughs of Hackney; Newham; Tower Hamlets; Waltham Forest; Redbridge; Barking and Dagenham; and Havering.



7. Our engagement strategy

- We are not consulting, we are engaging
- We are not asking permission to implement these programmes of work (except where the proposals is so new as to be a change in service), we are testing them, and asking for views on implementation. We should also be asking people to get involved in future work
- The breadth of TST means that there is a very limited number of people who will be interested in all aspects of the programme. Therefore **the majority of engagement will be at a local level about specific proposals** (initiatives) about what is important to local communities.

Responsibilities

TST programme communications

- Overarching key messages and collateral to introduce TST
- Establishment of communications framework (e.g. this strategy and plan)
- Coordination of three borough stakeholder meetings (e.g. JOSCs) and where a coordinated approach would add consistency and economy e.g. LMCs
- Establishment and coordination of methods of collation
- Facilitation of PPRG

TST programme (clusters and workstreams)

- Develop an engagement plan
- Develop cluster/workstream collateral to explain concepts and gain appropriate engagement
- Work with key stakeholders, staff, members of the public and patients to test and develop the proposals. This could be through focus groups, workshops or established groups

CCG communications teams

- Develop local collateral to explain how TST fits in with local plans
- Work with TST programme project managers to develop a locally appropriate engagement plan that dovetails with existing local engagement and meetings

Barts Health communications team

- Work with any/all of the above, to develop and deliver an engagement plan to staff
- Work with any/all of the above to assist in providing clinicians to speak at various forums

8. Alignment with other strategies / policies / issues

a) This communications and engagement strategy will need to align closely with the **organisational development and clinical leadership strategy**, to ensure the impact of both strategies is maximised

   An example of how this could work in practice is that the organisational development and clinical leadership strategy will need to take ownership of the programme to ensure it is delivered and implemented effectively. This will help to meet the aim of engaging CCG and Barts Health staff in the programme.

b) This implementation of this strategy will need to align with the **communications and engagement strategies of Newham, Tower Hamlets and Waltham Forest CCGs**.

c) All three CCGs (Newham, Tower Hamlets and Waltham Forest) have been approved to take on **fully delegated commissioning of local GP services**. The three CCGs have agreed to work together and will be developing a joint advisory board to oversee commissioning decisions. This should provide opportunities to better integrate care across the whole east London population – but will need to be explained.

d) **CQC inspections of Barts Health**. The trust is in special measures. The essential focus on these immediate issues may detract and/or complicate the focus on TST. The messaging has been (and continues to be) that TST addresses some of the underlying problems in the system and therefore has to be seen as part of the long term solution. It will also be important to highlight the positive aspects of Barts' care e.g. low mortality rates; some of the best stroke and major trauma care in the world; the Barts Heart Centre. Maintaining staff morale will be critical to the success of the trust and to the programme as a whole.

9. Our engagement plan

- The Strategy and Investment Case (SIC) was approved at the CCG governing body meetings in Tower Hamlets (26 January), Waltham Forest (27 January) and Newham (10 February); and at the Barts Health board on 3 February.
- The engagement will run for 12 weeks (29 February to midnight 22 May 2016).
- There are three documents:
    - Part 1: a summary to be tested with the Patient and Public Reference Group
    - Part 2: the main report
    - Part 3: the detail of the proposed high impact initiatives

We have already received feedback as the document has been drafted. Once the full document is publically available we will continue to invite comments from interested parties.

By engaging with stakeholders, we will be able to ensure commissioning decisions take into account public, patient and clinical views to ensure a safe service and excellent patient experience.

All engagement will build on links and relationships developed during previous engagement programmes (in particular Transforming Services, Changing Lives Case for Change (2014)).

Activity

The engagement plan includes:

- Drop-in sessions in each hospital
- A range of meetings / workshops and focus groups in each borough with staff, community and patient groups and representatives, and public to ask for their views.
- Media releases and adverts to be placed in the local press
- Offer of attending Overview and Scrutiny Committee meetings in each borough
- Offer to meet with Healthwatch, LMC and other stakeholders in each borough
- Monthly meetings with the Patient and Public Reference Group (PPRG)
- Production of a newsletter providing monthly updates on the programme
- Mail outs to interested parties asking for their views and the offer of a meeting (and requesting organisations mail out to their stakeholders e.g. council databases)

Collateral

A number of materials will be available throughout the engagement process to inform the public about the programme. These will include this engagement plan and:

- The Strategy and Investment Case
    - Part 1 – the summary
    - Part 2 – the main document
    - Part 3 – detail of the high impact initiatives
- Core presentation
- Advertisements and media releases
- Website and newsletters
- Questionnaire (on website and in the summary version to encourage feedback)
- Posters/banners for patient/public areas.

10. The high-level questions

We welcome your comments on any aspect of our proposals. However you may wish to think particularly about:

1. **Our strategy**	Prompts: Have we correctly set out the challenges? Is our overall strategy right? Are there issues we have not addressed well enough or at all?
2. Our investment case	Prompts: We plan to spend about £140 million over the next five years. We think this will help us meet the challenge of population growth and growing demand, make significant improvements and save the NHS around £300 million. Is this the right level of investment? Should we be more or less ambitious? Are our proposals achievable? Are any of them unnecessary?
3. The 13 high-impact initiatives	Prompts: Will these initiatives focus on the biggest challenges or on where they will make the biggest improvements? What issues should we bear in mind if we take them forward in their current format?
4. Do you have any other comments?	

Group	Engagement	Objectives	Responsibilities	Timescale
1. Staff	CCG engagement: • The CCGs and the three chief officers will lead on the engagement in each borough. This will include updates at staff meetings and briefings in staff newsletters and other internal communication channels.	To hear staff views Ensure a sense of ownership in each CCG about the TST programme so the proposals can be taken forward	CCG/TST/Comms	Ongoing
	• Ensure any engagement that is already happening locally in the CCGs is aligned to the TST strategy. This will be achieved through regular contact with the communications and other staff at the CCGs.	Ensure staff feel they have been involved in the programme and that TST is not just 'another thing'	CCG/Comms	Ongoing
	• Some of the changes will increase activity in primary care (e.g. moving some hospital appointments for patients with long-term conditions into primary care, where appropriate and where it will benefit the patient). The changes will occur at a time when primary care staff are already feeling overworked and demoralised. We will attend LMC meetings in each CCG area to engage with GPs	Develop NHS staff as potential ambassadors and drivers for change Help staff understand the impact of the proposals and allay fears they may have fears about the their jobs and understand the benefits for their future careers	GPs/TST/Comms	Ongoing
	Barts Health engagement: • Communicating with Barts Health staff is the responsibility of the trust; however the TST programme needs to work closely with communications and other staff at	Ensure a sense of ownership within the Trust about the TST programme so the proposals can be taken	BH/TST/Comms	Ongoing

	Barts Health to ensure their staff are informed about the programme and have the opportunity to engage. This will include providing materials and information for use within their internal channels, and working with them to arrange events and briefings. • Drop-in sessions will be held at each hospital site to inform staff, patients and carers about the programme	forward Ensure staff feel they have been involved in the programme and that TST is not just 'another thing' Allay fears staff may have about the their jobs and understand the benefits for their future careers Align key message with BH's safe and compassionate plan	BH/TST/Comms	During engagement process
2. Patients and carers	• Regular meetings of the TST patient and public reference group (PPRG) • Drop- in sessions at each hospital site to inform patients and carers about the programme • Drop-in sessions in each borough. These will be hosted by staff and clinicians involved in the TST programme and will be an opportunity for the public to have their questions	Hear the views of patients and carers Emphasise the message that this is not another NHS case of 'change for change's sake' Allay fears over potential extra travel to different sites for treatment Provide reassurance of the NHS commitment to clinical quality and patient care Help prevent ill health and improve the health of residents	TST/Comms BH/TST/Comms CCG/TST/Comms	Every month During engagement process During engagement process

3. Health Partners (local authorities, health and wellbeing board, charity and voluntary sectors)	• Regular updates through meetings and other communication channels • Attendance at key events	Ensure any impact on health partners are fully explored Utilise specialist knowledge of issues and opportunities Ensure synergy with partners' developments and announcements	Comms/TST Comms/TST	Ongoing Throughout engagement process
4. Community	• Drop-in sessions for the public. These will be hosted by staff and clinicians involved in the TST programme and will be an opportunity for the public to have their questions answered. One session will be held in each of the three boroughs and at each Barts Health site • Workstreams and additional events and workshops as necessary which will be focused on particular areas of the programme • Newsletter – several editions of a newsletter have been produced which provides updates on the TST programme. This will continue throughout the engagement process • Take out adverts in local papers • Website – the website http://www.transformingservices.org.uk/	Encourage members of the public to attend events to understand their needs Build trust in the NHS as effective caretakers of the health of the local population Help the public understand how the NHS works and the different services on offer Understand the needs of the residents Ensure their views are listened to	TST/Comms TST/Comms Comms Comms	Throughout engagement process Throughout engagement process Monthly Start and end of engagement process

	will be updated and continue to be a source of information for anyone with an interest in the TST programme		Comms	29 February
	• Literature and posters to be mailed out to Healthwatch and other stakeholders asking them to distribute and advertise in public areas		Comms	Start and throughout
	• Media release to inform members of the public		Comms	Throughout (see below)
	• Provide updates to CCG meetings with the public		CCG/Comms	Ongoing
5. Influencers (media, Mayor's office and London Assembly members, borough councillors)	• Adverts will be taken out in local papers	Ensure their views are listened to	Comms	29 February
	• A reactive statement will be agreed to respond to any questions on publication of the SIC on 20 January 2016	Facilitate them into providing reliable information to their readers/constituents	Comms	20 January 2016
	• A further, proactive release will be prepared which will outline the programme and the engagement in more detail		Comms	29 February
	• Another proactive release (half way through the engagement) will encourage people to get involved		Comms	Half way through engagement process
	• A final media release will be issued immediately following the closure of the engagement period		Comms	End of engagement process

	• Documents will be emailed to MPs and we will offer to meet with them to discuss further • Meetings with campaign groups such as Save our NHS • Details of the programme will be emailed to voluntary organisations and charities and we will offer to meet with them		Comms TST/Comms TST/Comms	29 May Throughout engagement process Throughout engagement process
6. Represent and regulate	• Attend meetings with the LMCs, NHS England, Royal Colleges, scrutiny committees and Healthwatch	Provide information as required under the NHS Act (OSCs) Receive independent endorsement for proposals and provide reassurance for relevant audiences Receive critical challenge and objective examination	TST/Comms	Throughout engagement process

11. FAQs

Q: Is this about closing hospitals?

A: No. Closing hospitals can save money and improve the quality of services but in East London, because of the expected extra 270,000 people, this would not be appropriate. Nor would opening a new hospital. We need to live within our means and reduce our reliance on hospital-based care.

Q: Will the Transforming Services Together programme solve the funding gap in this area?

A: Not completely – but it would play an important part in restoring balance.

Q: Will people have to travel further if you are proposing to consolidate some surgery?

A: Some people may have to travel further for their operation. However pre and post-operative assessments would mainly be done at the patient's local hospital. The proposals would reduce the number of cancelled operations and bring many services (such as outpatient) closer to home. So for most patients there will be a reduction in the need to travel. Patients would also benefit from shorter waiting times for surgery and improved outcomes.

12. Timeline

The engagement process will begin on the 29th February and last for 12 weeks. Analysis of the engagement period will then be incorporated into an engagement report for 17th June.

13. Risks and mitigations

Risk	Mitigation
1. Any proposed service moves from one hospital to another will be seen as 'downgrading'	• Lines to take will be developed to make it clear that all moves strengthen the offer at each site
2. Not all decision-makers fully understand the requirements for engagement and consultation, so services are changed prior to approval	• NEL CSU communications team attend programme meetings to advise decision-makers and others (as appropriate) on legislation, guidance and best practice in relation to service change
3. Everything focuses on small contentious changes when most of the programme is about being more efficient; making small-scale changes to streamline services and improve patient care	• Develop narrative around the smaller scale changes (such as new protocols) and the benefits they will bring, and emphasise in all communications to stakeholders

4. Impact of Barts Health being put into special measures, following publication of the CQC report on Whipps Cross Hospital. The need to address immediate issues may detract from the longer-term vision	• Continue to emphasise that action to address the immediate issues is crucial, but so is developing the longer term strategy, as this will address some of the root causes of the current challenges.
5. That ONEL/INEL JOSC do not support the proposals	• Send the documentation and plans to the JOSCs prior to engagement asking for comment; offer to meet with chairs and/or committees in advance; offer to meet with committees during the engagement
6. Risk of loss of momentum	• Ensure ownership of programme through engagement and getting staff members to present/discuss at every opportunity

As phase two of this programme may involve consultation on service changes, it is important to be mindful of the reasons why proposals for health service change in England are contested. The Independent Reconfiguration Panel advises that one of the most common reasons why proposals are referred is:

8. Health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care	• The financial implications will be clearly laid out • The clinical workstreams are asked to consider implications for travel in their impact analysis • There is an urgent and emergency care coordination workstream in place. There is clear consensus within this group that emergency care needs to be retained on all sites.

14. Evaluation

The success of the formal engagement will be measured by:

- Meeting milestones and adherence to action plan
- Key stakeholders (including patients) are aware and understand the issues
- Respondents' views on quality of proposals and of the process
- Relevance of views expressed and the improvements made on the proposals
- Processes are sound and do not allow successful legal/quasi-legal challenge.

These align with the aims and objectives outlined in part 2 of the Strategy and Investment Case.

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