Transforming Services Together

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

17 November 2016

Contents

1. Self-care ... 2

1.1 Introduction ... 2

1.2 Self-care delivery ... 4

1.3 Mapping existing WEL self-care interventions ... 7

1.4 London-wide self-care initiatives ... 7

1.5 Measuring success ... 8

1.6 Summary ... 8

2. Elective (planned) surgery ... 9

2.1 Background ... 9

2.2 Surgical Hub Benefits ... 10

2.3 Proposal ... 10

2.4 Surgery changes ... 12

3. Movement of services and patient journeys (acute patient pathways) ... 13

3.1 Introduction ... 13

3.2 Integrated care ... 14

3.3 Acute care hubs ... 15

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

1. Self-care

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

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

1.1 Introduction

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

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

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

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

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

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

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

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

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

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

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

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

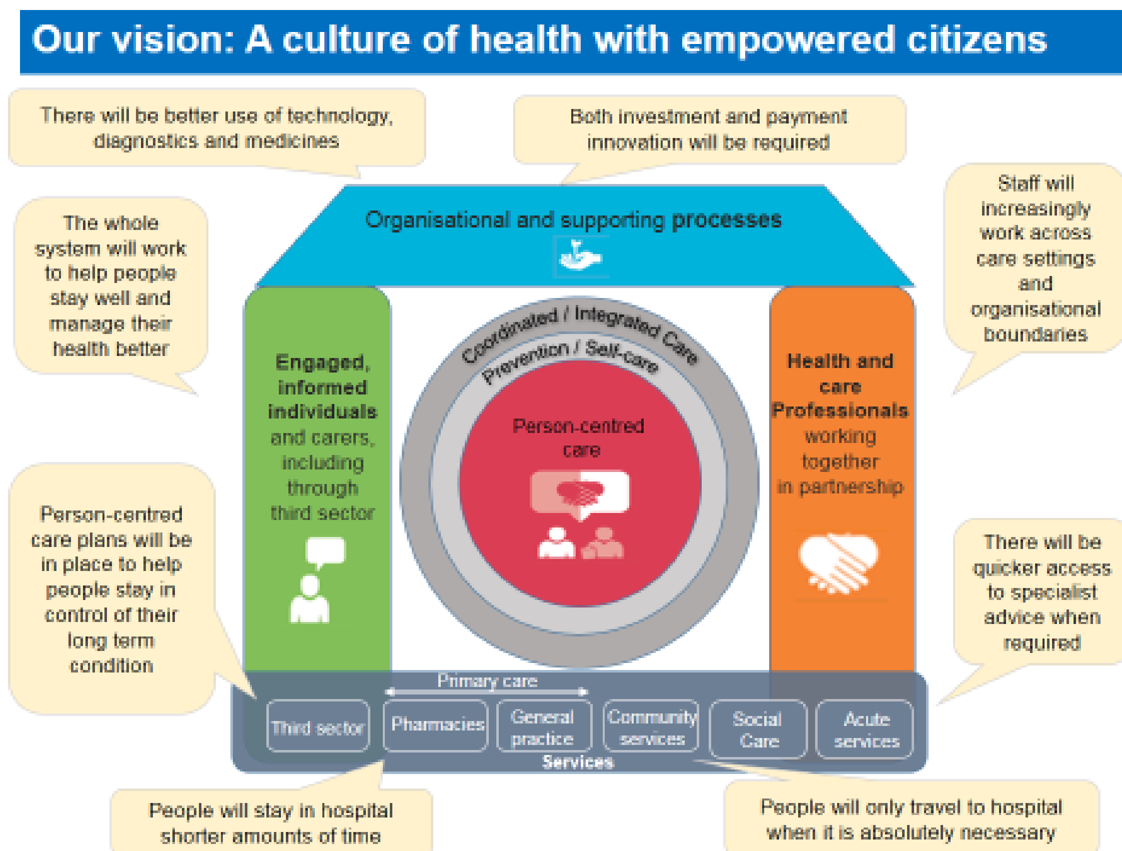

Figure 1

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

1.2 Self-care delivery

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

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

Primary care

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

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

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

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

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

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

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

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

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

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

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

Urgent care

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

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

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

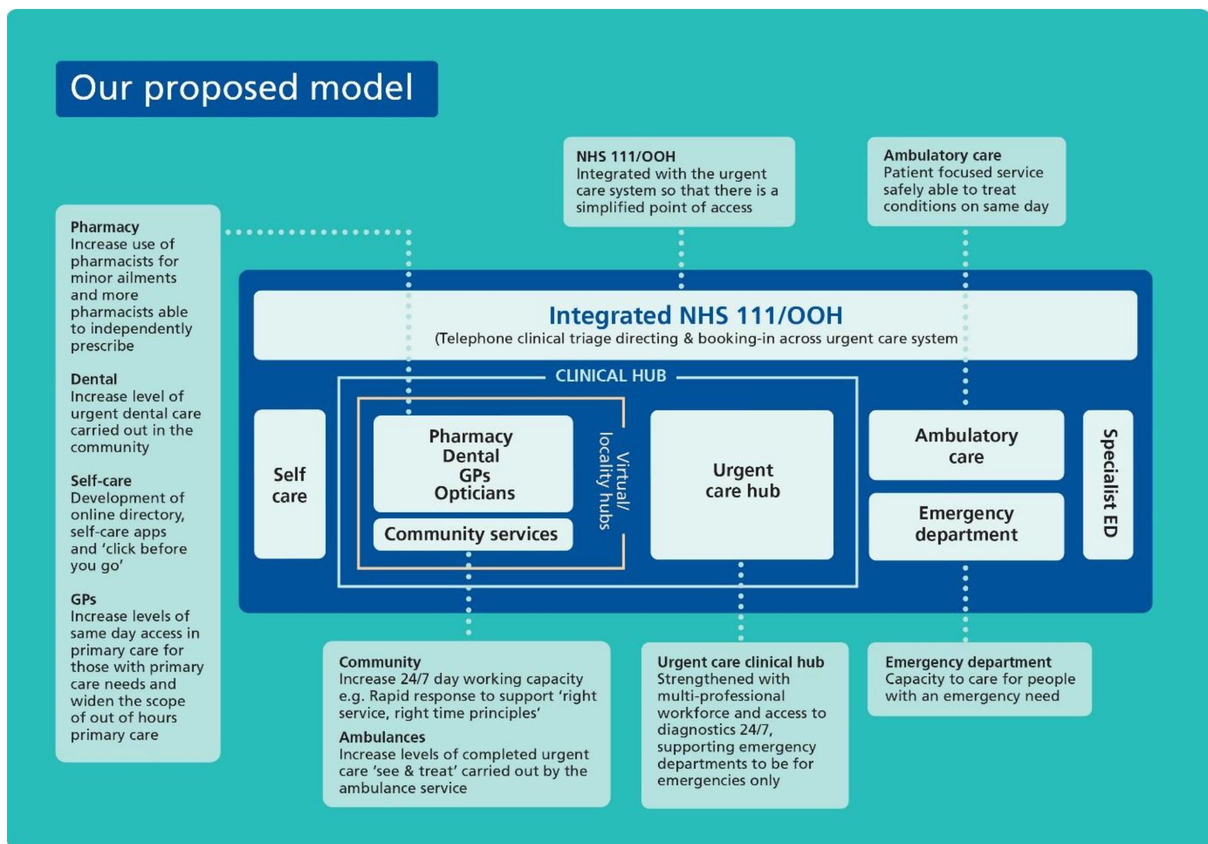

Figure 2

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

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

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

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

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

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

1.3 Mapping existing WEL self-care interventions

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

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

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

1.4 London-wide self-care initiatives

Strategic Partnerships

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

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

Social Prescribing

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

Integrated Personal Commissioning / Personal Health Budgets

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

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

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

1.5 Measuring success

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

Patient Activation Measures (PAM) [11]

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

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

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

1.6 Summary

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

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

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

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

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

2. Elective (planned) surgery

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

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

2.1 Background

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

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

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

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

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

2.2 Surgical Hub Benefits

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

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

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

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

2.3 Proposal

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

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

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

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

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

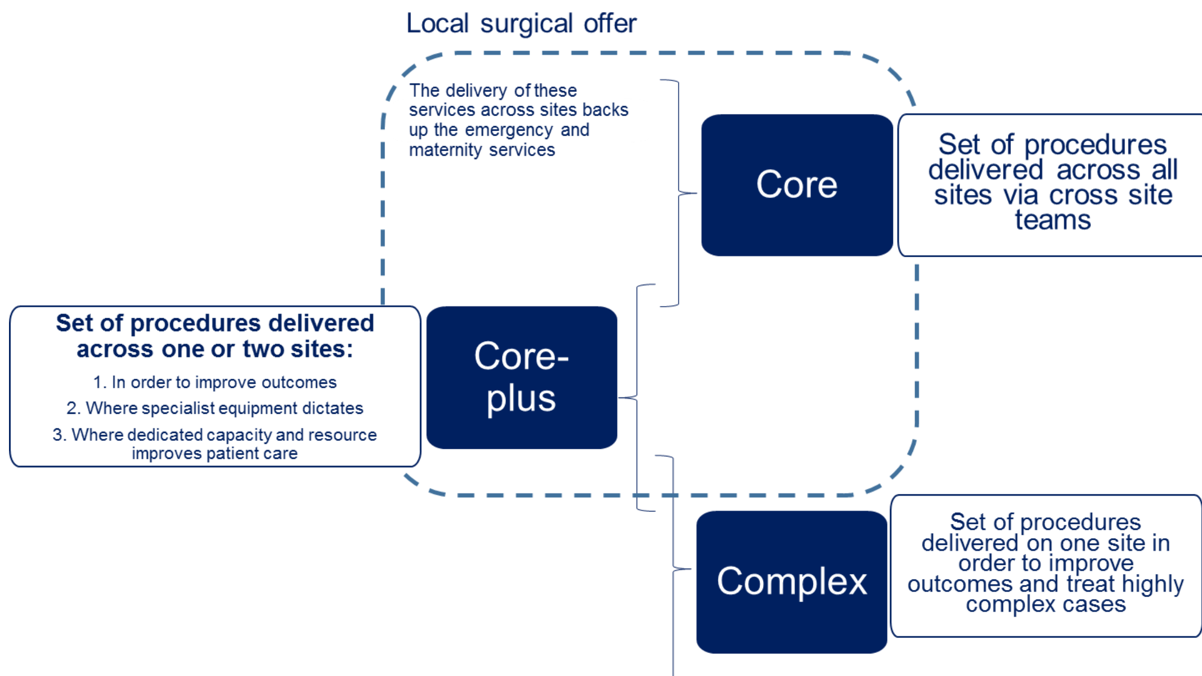

Figure 3

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

2.4 Surgery changes

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

- **Colorectal surgery**

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

- **Urology surgery**

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

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

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

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

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

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

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

3.1 Introduction

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

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

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

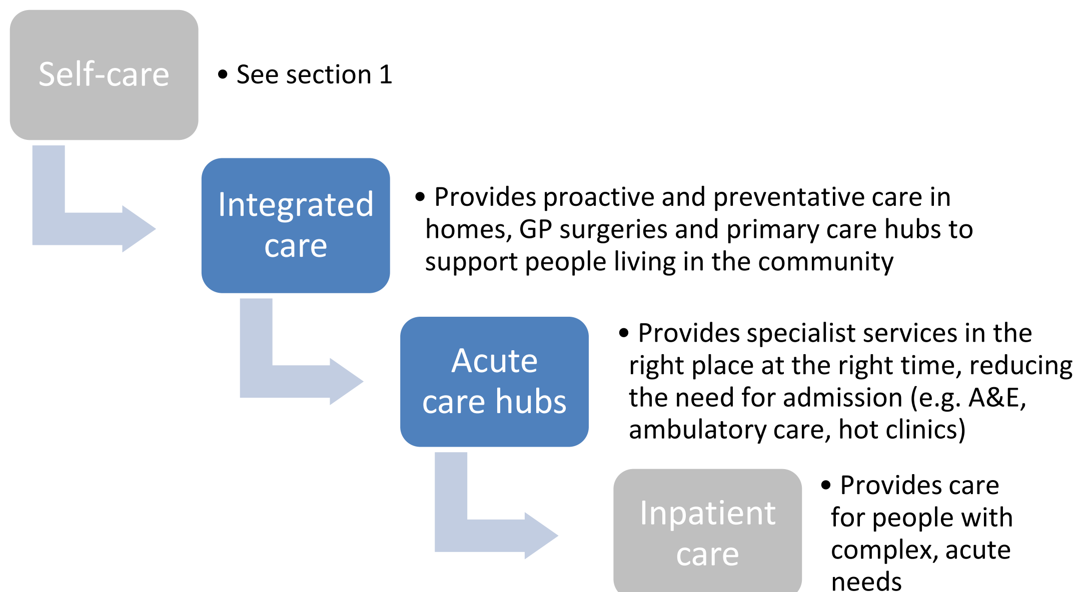

Figure 4

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

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

3.2 Integrated care

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

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

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

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

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

For example:

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

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

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

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

3.3 Acute care hubs

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

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

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

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

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

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

[17] Royal College of Physicians: *Future Hospitals Commission*. 2014 www.rcplondon.ac.uk/projects/future-hospital-commission
[18] www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-10-ambulatory-emergency-care

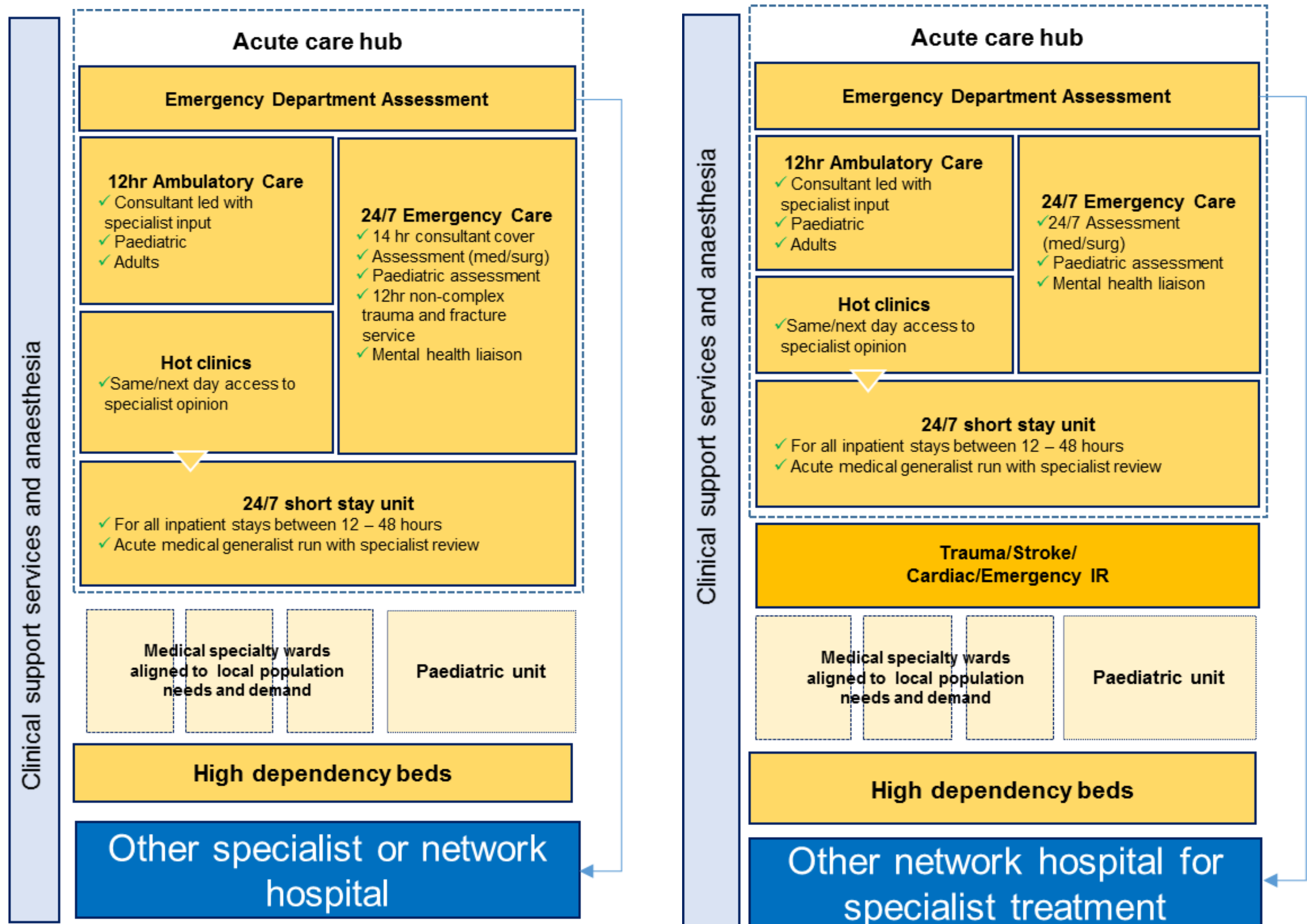

Figure 5

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

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

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

Case study:

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

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

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

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

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