Whipps Cross Health and Care Services Strategy

Refresh document

October 2020

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Executive summary

The Health and Care Services Strategy (HCSS) is the clinical strategy for Whipps Cross that also underpins the planned redevelopment of the hospital. The HCSS was developed with clinicians and staff across the Trust and the wider system in 2019. The work to further develop and implement the models of care envisaged, working with staff and patients, was not able to begin earlier this year because of the COVID pandemic and it has now been necessary to review the strategy in the light of this.

The COVID pandemic has had a significant impact on the health and care landscape and is expected to result in enduring changes to the operating environment for hospitals. In this context, it was important to review the HCSS to assess the need for any changes to the models of care envisaged. This paper summarises the outcome of this review.

The core components of the HCSS remain valid. First, the hospital will continue to deliver the same core services as today, including Accident and Emergency and Maternity services. Second, it remains the aspiration that Whipps Cross becomes renowned for the integrated treatment and care of frail and older people within its catchment area.

Much of the transformation of services that has happened in response to COVID aligns with the direction of the strategy. On urgent care, the Urgent Treatment Centre (UTC) and Same Day Emergency Care (SDEC) services have been separated from the Emergency Department (ED) and there has been successful collaboration with community teams on admission avoidance and early discharge pathways. On planned care, the strategy's proposed shift towards more virtual outpatient appointments has been significantly advanced, as has the clinical triage of referrals.

Moreover, the guidance for health and care systems published in the wake of COVID describes future ways of working that are closely aligned with the changes envisaged in the original HCSS; minimising time in hospital, improved triage at the front of pathways, consolidation of specialist services and management of long-term conditions in the community. As a result, the HCSS remains the right overall strategy to underpin the hospital redevelopment.

As part of developing the strategic outline case for the redevelopment, we undertook activity modelling to forecast the likely future activity of the new hospital. To do this, we looked at projected population growth and other demand factors and set against that the likely impact of delivery of the proposed care models (using peer benchmarking) that aim to reduce time spent in hospital. In light of the changes in hospital activity seen over the COVID period, we have revisited these assumptions to test that they are still relevant. We believe they are and that the emerging evidence from the last six months, if anything, reinforces our confidence in future delivery.

Nevertheless, the need to take account of the enduring impact of changes made in response to COVID inevitably means that there are some elements of the strategy that require review, specifically:

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1. Updates to the **models of care** – in particular there will be changes to the 'front door' model. Given the guidance on changes to the front end of urgent care pathways (i.e. a single point of access), the way in which people access the 'front door' of the hospital will be different from the expectation in the original HCSS. More people will access the hospital by referral from services in the community (e.g. GPs, NHS 111, primary care 'hot hubs'), meaning fewer people arriving on site as 'walk-ins'.

2. Updates to the **scope of services** - the scope of services as described in the HCSS is aligned with the recommendations of the Barts Health Surgical Strategy. The Trust remains committed to the Surgical Strategy and the response to COVID has resulted in the development of a North East London (NEL) sector-wide elective care strategy, which is an opportunity to broaden our work to include other providers in NEL. The NEL strategy is in development and may alter the precise scope of surgical services at Whipps Cross Hospital. This could modestly change the scale of services at the hospital and, therefore, the requirements for the new hospital estate.

3. Updates to the **hospital design brief** – these include:
    a. Adjustment to the estimated space requirements to account for changes to the models of care and scope of services; and
    b. Changes to design principles to reflect infection control measures and future proofing the hospital including:
        i. Increasing the number of side rooms;
        ii. Increasing the number of entrances to the hospital;
        iii. Designing waiting areas to allow for effective infection control, for example more physical barriers to isolate patients before and during assessment; and
        iv. Designing ward space to allow for increased flexibility and the ability to divide bedded areas effectively.

In addition to these strategic changes, there will also be changes to the implementation timeline for the HCSS. Given the work that is already in train as a result of COVID (e.g. the shift to significantly more virtual appointments), it is sensible to reprioritise those areas in the implementation of the HCSS. Moreover, the requirement to plan for possible future COVID peaks has clearly delineated the scale of the challenge in effectively managing the hospital bed base and there is an increased interdependency with having to work with system partner organisations to deliver this. This was already a critical element of the HCSS, which will continue to be accelerated.

Moreover, it will be important to continue to learn from the pandemic as it develops. This review considers some of the most significant impacts of COVID to date, but there will be much more evidence and input to be considered going forward and the programme will be managed to incorporate further input as we learn more about the long-term impact of the pandemic.

This paper identifies some areas for which further work is required to agree the specific changes required to the HCSS. The most critical of these are:

- the future of the UTC in an updated 'front door' model;

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- the optimal use of the flexible space (sometimes referred to as the ‘F block’) to be built on the hospital site, so that other non-hospital health and care services can benefit from being provided alongside the hospital itself; and
- the precise service changes as a result of the NEL sector-wide elective care strategy.

Addressing these further lines of enquiry will require close working with patient and the public representatives and system partner organisations both within Waltham Forest and Redbridge as well as across north east London more broadly. This will be delivered through the establishment of the HCSS governance structure, which will report to the Whipps Cross Strategic Partnership Board and the Whipps Cross Redevelopment Programme Executive.

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1 Purpose

The purpose of this document is to provide an assessment of the impact of the COVID pandemic on the Whipps Cross Hospital Health and Care Services Strategy (HCSS).

The redevelopment of the Whipps Cross Hospital site has long been an objective of Barts Health NHS Trust. In August 2019, Barts Health Board approved the Health and Care Services Strategy (HCSS). This strategy set out new clinical models for the hospital and new ways of working with system partners to underpin the planned redevelopment.

In March 2020, work began on detailed implementation planning. However, this was interrupted by the COVID-19 pandemic, which rightly has consumed much of the planning and delivery resource of the hospital since then. The challenge of managing the first COVID peak has highlighted again the deficiencies of the Whipps Cross hospital estate and strengthened the case for redevelopment.

In the aftermath of the first COVID peak, the redevelopment, and therefore the delivery of the HCSS, remains a critical objective for the Trust. Given the increased pressure that will be placed on the Whipps Cross site over the coming period, in relation to providing segregation between elective and non-elective care and the deployment of IPC measures, the delivery of the HCSS is a priority.

COVID has dramatically altered the context of health and care services over the short term, and longer term effects are uncertain. Since the advent of the pandemic, we have seen unprecedented changes to ways of working both within the hospital and with the wider system and to patient behaviour. Some transformation work has been paused while some has been accelerated. The impact of COVID on the health and care system has implications for the models of care and system partnerships described in the HCSS and as a result, for the design of the future hospital.

We have conducted a review of the HCSS in this context and this document sets out the findings of this review.

2 Context

In 2019, Whipps Cross Hospital developed the HCSS to underpin the planned redevelopment of the hospital site. The strategy describes new models of care within the hospital including the reconfiguration of the hospital front door, a new specialist triage service for planned outpatient and inpatient care, alongside implementation of the wider Barts Health Surgical Strategy. The strategy also sets out the aspiration for closer partnership working with the wider health and care systems in Waltham Forest, Redbridge and West Essex to promote health and wellness for residents, to provide preventative care and to enhance discharge support in the community.

Developing this strategy was an extensive process of engagement and data analysis which included:

- Engagement with more than 190 unique stakeholders from Whipps Cross Hospital (WXH), Barts Health, Waltham Forest (WF) Clinical Commissioning Group (CCG), BHR CCG, WF/Barking Havering and Redbridge (BHR)Primary Care, WF Council and North East London Foundation Trust (NELFT)
- Delivery of 34 workshops with service teams from across the hospital
- Analysis to produce an activity baseline and forecast projections
- Development of service strategies, including patient pathways, models of care and key co-locations

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The strategy was approved by the Whipps Cross Hospital Executive Board, the Barts Health Trust Board and the North East London Clinical Senate.

The COVID pandemic has had a significant impact on the activity of health and care systems, and has added volatility with frequent changes to national guidance, particularly around system working and Infection Prevention & Control.

Due to the change in context as a consequence of COVID the refresh of the HCSS has been completed through a process of engagement and analysis:

- Engagement with stakeholders from WXH, Barts Health, WEL CCGs and the NEL system
- Delivery of a workshop with key stakeholders from WXH
- Desktop review of national and local guidance and planning documentation
- Review of clinical activity baselines and projections against actual activity from 2019/20

3 Impacts of COVID

COVID has undoubtedly altered the operating environment for health and care system. Whilst the enduring effects cannot yet be fully understood, the effects we have seen so far are useful indicators. This review has highlighted three areas where we expect an enduring impact for the system. This is not an exhaustive assessment of the impact of COVID but rather a summary of the most significant changes in the context of the HCSS.

1. Patient behaviour
2. Clinical ways of working
3. New planning guidance

3.1 Patient behaviour

Patient behaviour changed dramatically over a short time period. There was a significant reduction in patients presenting at hospital and in patients being admitted (**Figure 1**). While part of this can be attributed to fear about contracting COVID and to government public health measures, patients have made increased use of out of hospital services. Primary care services such as primary care hot hubs, home monitoring services and NHS 111 were expanded, and have seen increased utilisation (**Figure 2**). These services, among others, supported people with long term conditions to manage their conditions without the need to attend hospital. In addition, initiatives such as Advance Care Planning were expanded to care home patients and those on end of life pathways in the community. Whatever the reason, over the COVID period, patients stopped presenting to the Emergency department as the default point of access for urgent care.

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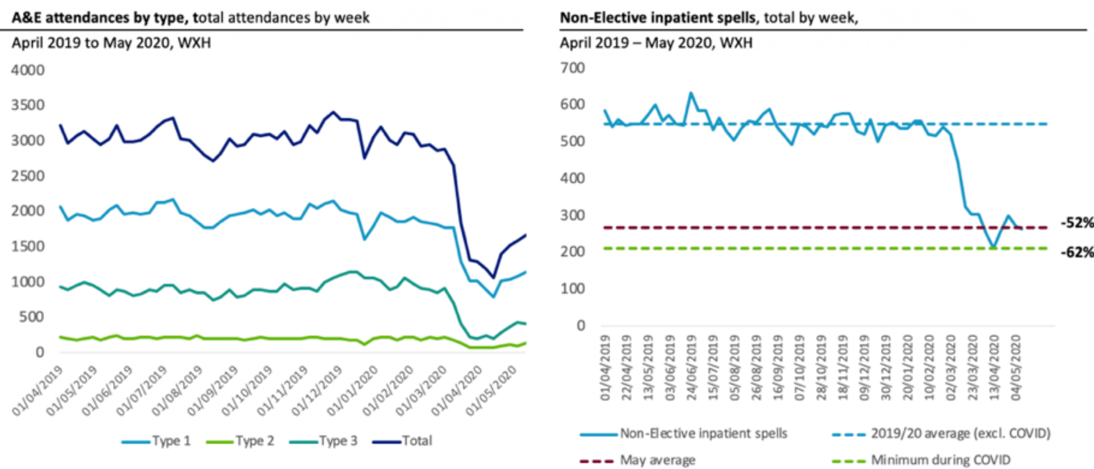
Figure 1: A&E attendances and non-elective admissions at WXH from April 2019 to May 2020

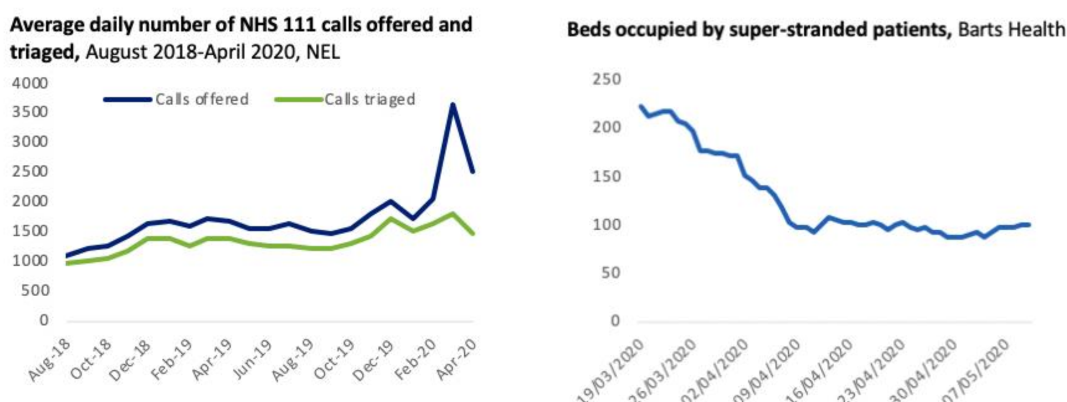


It is important to note that there is evidence that some patients who did not attend hospital will have poorer outcomes as a result. For example, nationally there was a 50% reduction in presentations of patients with suspected heart attacks. Therefore, changes to patient behavior and the impact on UEC activity during COVID is not necessarily something to be furthered, but is a useful as evidence that changes to the UEC model at scale are possible. This would be reliant on sustainable community services and on clear public communications setting out to access care, and when to attend hospital in an emergency.

3.1 Clinical ways of working

Over the COVID period, the Trust and its system partners successfully implemented a number of changes to clinical and operational practice. Community admission avoidance pathways were developed and new clinical guidelines for admission within the hospital were put in place to reduce pressure on the front door. New national guidance was issued in March 2020to facilitate effective discharge of patients from hospital. This led to the establishment of borough-based discharge hubs to support the rapid implementation of the discharge to assess model and community resources were expanded to provide more support to discharged patients. New clinical guidelines for discharge were also developed within the hospital. We can see that the number of hospital beds occupied by super-stranded (patients who have spent more than 21 days in hospital) patients significantly decreased over the period (**Figure 2**).

Figure 2: Calls to NHS 111 from NEL and beds occupied by super-stranded patients within Barts Health



Delivering more patient care virtually is a key ambition of transformation, particularly for outpatient services. During the COVID pandemic, a significantly higher volume of outpatient consultations were delivered virtually either by telephone or video consultations. The use of the advice and guidance service was also expanded across all specialties to allow patients increased access to specialist input through primary care, avoiding a visit to hospital. While some outpatient activity cannot be delivered virtually and will need to return to a face-to-face setting, the extent to which outpatient care has been delivered virtually during the pandemic has shown the potential scale of transformation.

3.2 New planning guidance

Following the first wave of the pandemic, regulators have published planning guidance which sets out the short, medium and long-term requirements for health and care systems going forward. Of the many documents published we have identified four documents which are most relevant to the implementation of the HCSS as these set out what systems need to achieve in the short, medium and long term.

1. **Simon Steven's letter** of 29th April 2020 sets out expectations for the immediate 6 weeks. This includes stepping up non-COVID urgent services as soon as possible and restoring non-urgent elective care. The letter also emphasizes the importance of sustaining beneficial changes that have been achieved in recent weeks.

2. **Journey to a New Health and Care System** of 24th April

3. **Sir David Sloman's letter** of 29th April

   These two documents set out expectations for London Integrated Care Systems (ICSs) over the next 12-18 months. This includes reconfiguration to meet demand for COVID, non-COVID and elective services. They stress the need to evaluate the impact of recent changes, and to work with stakeholders and the public to shape the new health and care system. The new health and social care system will be implemented alongside new governance structures.

4. **Infection, Prevention and Control guidance** of 11th May states that elective and non-elective work should be separated as far as possible using rigorous Infection Prevention and control (IPC) measures, with the aim of eliminating the risk of hospital acquired infection, so that elective activity can be maintained. This entails physical separation of patients and facilities, and separate staffing rotas for elective and non-elective pathways. Elective patients should be screened in advance of attending hospital, and non-elective care should be carefully managed to reduce the risk of transmission when patients' COVID status is not confirmed. This is underpinned by usage of PPE in line with national guidance, robust staff testing and strict cleaning protocols. Updates to the guidance were released on 18th June and 20th August.

Regional and local teams have begun to develop plans in response to this guidance, which have implications for how the system in NEL will operate, and for Whipps Cross Hospital.

- **Systems will be required to plan to implement changes to the front end of pathways.** In North East London (NEL), the emergency care pathway from ED, UTC, GP hubs, primary care and 111 will develop a single point of access to prevent unnecessary attendances at hospital front doors. 'Help us to help you' will include a single point of access through 111 and clinical prioritisation to reduce walk ins. GPs will be provided emergency access to unscheduled care. ED alternatives (Same Day Emergency Care, specialty hot clinics, and frailty services)

should allow patients to bypass ED. The Physicians Response Unit will be expanded to allow more patients to received urgent care at home without the need for hospital attendance.

- **Hospital stays should be minimised.** Across NEL, discharge teams and Multi-Disciplinary Team (MDT) working in the community will be strengthened, community bed capacity will be expanded and the model of care to support care homes will be improved. In Waltham Forest, the discharge to assess model implemented over the COVID period will be maintained through a dedicated discharge hub. The home monitoring service will also be sustained with General Practitioner (GP) oversight.

- In order to comply with IPC guidance, **service segregation** will be implemented across all areas of health and care in NEL, including hot hubs in the community and ward segregation on hospital sites. Elective services will be consolidated across hospital sites across NEL (including Homerton and BHRUT) with lead providers being designated on a specialty by specialty basis. The purpose of this is to most effectively separate elective activity flows where patients have been tested for COVID-19 from other streams of activity.

- **Services should be run virtually by default**, unless there is a good reason not to. In NEL, outpatient, primary care and community services have been operating in this way and will continue to do so. Where patients need to attend in person, patients will be risk stratified with one-stop diagnostics to achieve maximum value from each hospital attendance.

This planning has implications for Whipps Cross specifically. SDEC and the UTC have already been moved away from ED and within ED, there is streaming of COVID and non-COVID patients. The hospital will now maintain 17 critical care beds to manage future increase in COVID patients requiring intensive care. Changes to elective services may impact on the scope of services at Whipps Cross and these impacts are explored in more detail in the following section.

4 Reviewing the HCSS

The HCSS is a clinical strategy which describes the future models of care within the hospital and the expected scale of services to be delivered at a redeveloped Whipps Cross hospital site. The impacts of COVID as described above have implications for this clinical strategy. Specifically, we have reviewed the HCSS with respect to the implications of COVID for:

1. Models of care
2. The scope and scale of services
3. Hospital design
4. Working with system partners
5. Enablers

The following section sets out how we expect COVID to impact on each of these areas.

4.1 Models of care

The HCSS outlines six models of care:

- Urgent and Emergency Care
- Planned Care
- Cancer

- Maternity
- Children and young people
- End of life/palliative

Given the impacts of COVID and the focus of the latest planning guidance and system plans in development, as described in section 3, all of these models remain valid and are aligned with the direction of travel for North East London. Nevertheless, some of the impacts described already are directly relevant to the Urgent and Emergency Care model and the Planned Care model and therefore we have examined these models in more detail for the purpose of this paper.

Urgent and Emergency Care model

UEC model as proposed in the HCSS 2019

The Urgent and Emergency Care model described in the HCSS was designed so that patients are directed to the most appropriate services for their needs, and receive advice, care, diagnosis and treatment, as fast as possible. The facilities at the front door were organised on the basis of patient need:

- The **emergency department** will be comprised of 'majors' and 'resuscitation', seeing only those patients with life-threatening and serious injuries. This is also attached to a specialist triage service, which will assess the needs of patients and whether they could be treated more effectively elsewhere (such as in the same day emergency service, a hot clinic or an inpatient ward). The specialist triage hub will play a vital role and will ensure that specialists are able to quickly determine how severe someone's illness or injury is and send them to the best place for treatment.
- The **urgent treatment centre** is a GP-led service and will see patients with minor injuries and illnesses. This separation between the emergency department and the urgent treatment centre means that both sets of patients are seen promptly, and the level of care available is appropriate for their needs.
- The **same day emergency care** (SDEC) service will support those patients who, under traditional models of care, would normally be admitted to hospital. Patients with urgent needs access these services once any requirements for immediate treatment are seen to. Here, patients with a wide-range of conditions can be assessed, diagnosed, treated and discharged home all on the same day.
- These services can be directly accessed through GP referral or ambulance. When patients arrive at the hospital without a referral, they will access services through a **nurse-led streaming process**. The streaming service can also be supported by other health professionals, including nurse-practitioner, physician-associates and Allied Health Professionals. From here, patients will be sent to either the specialist triage service or the urgent treatment centre

Transformation of the front door over the COVID period

Over the COVID period there has been significant change to the configuration of front door services. Some of these changes are in line with the HCSS, whilst some is additional. The primary changes are:

- The UTC and SDEC service are established and have been co-located away from the ED as per the proposal in the HCSS. These services are currently located in the Outpatient building which is unlikely to be sustainable in the medium to long term Streaming at front door has been strengthened in order to separate COVID and non-COVID presentations.

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- The frailty assessment unit which was on site has been replaced with a frailty pathway in the community in collaboration with primary and community care

Relevant guidance, planning and service changes

There are two key pieces of guidance relevant to the development of the Urgent and Emergency Care model. First, there is an expectation set out in 'Journey to a New Health and Care System' regarding the creation of single points of access for urgent care to provide effective triage at the front end of all pathways. This expectation has been repeated by Simon Stevens through the launch of the 'Help us help you' initiative aimed at encouraging people to seek treatment when they need it through primary care and NHS 111 or 999 in emergencies, and to only attend hospital if they are told they should. The implication of this guidance is that health and care systems should design urgent care pathways with virtual triage through primary care services (including NHS 111) and thus reduce the level of walk-in attendances at the hospital front door.

Second, the latest Infection Prevention and Control guidance states that hospital front doors should have separate areas for high and low risk of COVID based on presenting symptoms, as well as isolation areas for vulnerable patients that need shielding. The implication of this for the UEC model is a greater space requirement to facilitate social distancing, avoid overcrowding and facilitate shielding of vulnerable patients.

Suggested revisions to the UEC model as described in the HCSS

Given the guidance described above and its implications, the UEC model will be revised to include access to unscheduled services for GPs and the introduction of timed appointments in ED and other front door services to reduce walk ins.

In Waltham Forest and east London (WEL), the COVID Emergency Group (COVEG) has been established to be responsible for the implementation of the *'Help us, help you'* guidance and the requirement to reduce volumes within ED waiting rooms to prevent nosocomial spread of COVID 19. Therefore this work will define the new pathway for emergency access to secondary care and therefore the revisions to the UEC model at Whipps Cross.

This work is currently in progress but initial planning work indicates the following changes from the front door model as originally stated in the HCSS:

- Nurse led streaming at the front door will be replaced with the Barts Emergency Access Coordination Hub which will triage referrals to ED – the 'help us help you' model will significantly reduce walk-ins at A&E, primarily replaced by bookings into the appropriate clinic for patients who require face to face contact or virtual support
- The frailty assessment unit at the front door should be replaced by a community based frailty pathway, which should serve to minimize the number of frail patients arriving at the hospital in the first place

The guidance described above also have implications for the design brief for the front door:

- A single point of access for urgent care and virtual triage in the community would result in reduced footfall at the front and this implies a smaller space requirement – the 'help us help you' model would remove the need for a significant waiting area as all attendances at ED should be through referrals from the single point of access in the community

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- However, infection control guidance implies a larger space requirement given the need for more side rooms for assessment will be needed to support cohorting and shielding and all cubicles will need doors

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Planned Care model

Planned care model as proposed in the HCSS 2019

The Planned Care model as described in the HCSS places much emphasis on specialist triage to ensure that patients are treated in the facility most appropriate for their needs, as swiftly as possible.

- Everyone, regardless of whether they are a new referral or a patient requiring ongoing chronic disease management, will initially be referred to a Specialist Triage Function
- All referrals and requests for advice will follow the same process and be dealt with promptly, providing same day triage, when possible
- The specialist triage will coordinate care for outpatients and elective surgery - unlike the hub in the non-elective model, the function here can operate virtually, and will focus on processing referrals, ensuring that patients are directed to the most appropriate specialist services as quickly as possible
- The specialist triage function will play a critical role in delivering a greater amount of outpatient care under a one stop model - making sure that patients have diagnostics and receive their result on the same day (where possible) will reduce the number of attendances to hospital
- For patients with multiple needs, this will require contact with the care coordinator. Within this model, we will also increase the number of joint clinics delivered, strengthening the links between specialties to benefit patients

Transformation of planned care over the COVID period

Over the COVID period many of the hospital's planned care services were suspended in order to ensure adequate capacity in hospital for COVID patients. Many outpatient services were sustained but delivery was radically transformed in order to make these services as safe as possible for patients. Outpatient services were transformed in the following ways:

- Senior clinical triage was put in place for outpatient referrals and the advice and guidance service for primary care is now in place across all specialties (though uptake is still low in many specialties) – the establishment of this triage service was facilitated by the redeployment of resource from the suspension of certain planned services
- A significant shift to virtual outpatient appointments has been delivered across all specialties and the requirements of COVID have demonstrated the feasibility of a much larger proportion of virtual appointments than previously expected
- The system for consultant to consultant referrals has been updated and all referrals now go through a digital system – however there remain operational challenges with this system related to the scheduling of appointments

All of this transformation is aligned with the original HCSS model and should ideally be sustained in the long term. Much of the enabling work to support this change has been achieved over the COVID period through redeploying resource, but also within the existing constraints of these resources, for example the technology and infrastructure currently available to support remote working and virtual patient care. Therefore further work will be required to sustain this change in the long term, particularly around the critical enablers i.e. digital and workforce. Work will be needed to review the changes that have been made, to identify what has worked well and where there are opportunities to make improvements, in order to make sure that the resources to deliver services are future-proof.

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Relevant guidance, planning and service changes

There are two pieces of guidance and related planning work that are particularly relevant for the development of the planned care model. First, expectation three described in 'Journey to a New Health and Care System' makes virtual by default a core principle in future system planning. This confirms the need to sustain the shift to virtual in outpatient services and the scope of appointments that are suitable for virtual delivery is likely to be expanded as a result.

Second, a primary requirement of recent planning guidance has been the 'strict segregation of the health & care system between COVID and non-COVID, and a much stricter separation between urgent and elective work, especially by site'. There is significant planning in progress to fulfil this requirement across the system including the development of a NEL elective strategy which sets out plans for consolidation of planned care across the sector. This planning includes the intention to work through the elective backlog and the creation of diagnostic centres (e.g. Mile End), both of which will impact the delivery of planned care at Whipps Cross Hospital.

Suggested revisions to the Planned Care model as described in the HCSS

Given the guidance described above and its implications, the Planned Care model of care will not need significant revision, but there will be changes to the scope of services delivered at the hospital site:

- The NEL elective strategy will build on the Barts Health Surgical Strategy and is likely to result in an acceleration of the service moves described in the Surgical Strategy as well as the widening of sector-side opportunities for the creation of high volume centres for low complexity elective surgery

The plans described above also have implications for the design brief for the hospital as the shift to virtual will alter the nature of the space required to deliver outpatient services e.g. dedicated private space to conduct virtual appointments.

4.2 Scope and scale of services

The HCSS includes detailed activity modelling which forecasts the expected scale of services at the Whipps Cross site. This provides a guide to the space requirement for a new hospital estate to deliver these services. This modelling was based on:

- Baseline 'do nothing' projections given historic activity and projections of local demographic growth
- A defined scope of services that will be offered at the future hospital site in line with local planning work (e.g. Barts Health Surgical Strategy, Maternity Business Case)
- The development of a 'do something' forecast based on the application of opportunities to reduce the number of people coming to hospital and the time people spend in hospital, arrived at through benchmarking analysis of A&E attendances, admissions, length of stay and virtual appointments

It is important that we revisit the activity forecasts in light of the COVID pandemic to understand whether any of the impacts identified will have a material impact on the size of the future hospital.

In considering the impact of COVID as detailed earlier in this document, we have reviewed this forecast in two key ways by:

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1. Reviewing the opportunities to reduce activity considering the evidence of activity changes over the COVID period
2. Redefining the possible scope of services to be provided at the site based on the emerging system planning work

4.2.1 Review of the scale of services

The Whipps Cross Hospital modelling from 2019 contained assumptions around how changes to the models of care and improved system working would have an impact on hospital activity and make sure patients receive the right care in the right place at the right time by:

- avoiding unnecessary A&E attendances,
- avoiding unnecessary inpatient admissions,
- ensuring that length of stay in hospital is as short as possible
- converting "face-to-face" outpatient attendances to virtual.

These opportunity assumptions were based on peer benchmarking with other similar hospitals. COVID has provided an opportunity to review this. We now therefore have an alternative "internal" benchmark for Whipps Cross, based on the observed reduction in activity during the pandemic and the work which took place around attendance and admission avoidance, expedited discharge and the increase in virtual outpatient care.

Avoiding unnecessary A&E attendances:

Of the people who did not attend hospital over this period, there is a cohort that needed acute care but did not attend, and there is a cohort that required care that was, or could have been, managed in a different setting. For A&E attendances, we have analysed data from the COVID period at diagnosis code level to understand the level of activity reduction that reflects a true reduction in unnecessary acute activity, compared with activity that we expect should be fully restored after COVID.

Avoiding unnecessary inpatient admissions:

The data analysis has shown that the reduction in A&E attendances has caused a commensurate reduction in unnecessary inpatient admissions.

Minimising average length of stay:

We have compared the average length of stay in March 2020 (following implementation of the national "COVID-19 Hospital Discharge Service Requirements") with the length of stay in 2018/19. This particular data refresh only includes specialty groupings where the changes in activity could have a material impact on the size of the hospital.

Converting "face to face" outpatient attendances to "virtual":

A significantly higher proportion of consultations have taken place virtually during the pandemic, which suggests that the original opportunity can be increased to at least 50% of attendances being conducted virtually in the future.

The summary outputs of this analysis are shown below (Figure 3):

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Figure 3: Summary of opportunity analysis benchmarking from original HCSS modelling and from COVID-period data analysis

			Original HCSS opportunity peer benchmarking	Result of COVID internal benchmarking
A&E attendances	0-16 age group		-27%	-32%
	17+ age group		-18%	-23%
Admission avoidance	Ambulatory care	Surgery (Adults)	-3%	-6%
		Medicine (Adults)	-7%	-13%
	Non-elective inpatient	Surgery (Adults)	-3%	-8%
		Medicine (Adults)	-17%	-20%
Length of stay	Non-elective inpatient	Surgery (Adults)	-52%	-20%
		Medicine (Adults)	-13%	-19%
		Maternity	0%	-8%
Outpatients	Conversion to virtual		30% (Opportunity applies to follow-up attendances)	50% (Opportunity applies to follow-up attendances)

This analysis provides a useful sense check of the modelling that took place when the HCSS was developed. A number of those modelling assumptions were based on improved integrated working between primary and secondary care and the local authority, supporting improved community provision and access. The local pandemic response, which was centred around a multi-provider response from primary care, the local authority, community trust and hospital, strengthened access to services in the community and hastened the changes outlined in the original HCSS document

The analysis does not suggest that the plan for the *size* of the future hospital needs to change, however, there may be some differences in the *configuration* of the space, for example to deliver more virtual outpatient consultations.

In some areas, the analysis suggests that there may be the ability to develop the ambition to minimise unnecessary activity further. This would need to be considered in line with continued integration with community services, and activity changes proposed by North East London ICS. As such, our current plans for the size of the future hospital remain unchanged.

4.2.2 Review of the scope of services

The Barts Health Surgical Strategy seeks to optimise the location of surgical services at hospital sites within the Barts Health footprint in order to achieve optimum co-locations and volumes of activity. When planning for the future scale and scope of services at Whipps Cross, the HCSS takes the Surgical Strategy into account and any consequent consolidation of services onto or away from the Whipps Cross site up to 2028/29.

In the face of the COVID pandemic, some of these service moves within Barts Health may take place earlier than planned. Additionally, further service moves across NEL as a whole may take place as a result of the COVID pandemic, however, many of these changes are likely to be temporary.

The London planning guidance requires the consolidation of some low complexity elective surgical activity onto a smaller number of sites in order to give us the best chance of keeping these services

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running during future waves of the pandemic. In response to this guidance North East London is developing a sector wide elective strategy which builds on the Barts Health Surgical Strategy and includes plans for the consolidation of complex elective surgery and the creation of high volume centres for simple elective activity. Individual sites may become lead providers for a certain specialty, and waiting lists are to be managed at sector level in order to ensure equity of patient access. This emerging elective strategy has implications for Whipps Cross, which is likely to host high volume centres for ophthalmology, ENT and urology during the next phase of the pandemic.

These changes may have implications for the future elective capacity required at Whipps Cross which we need to work through carefully, particularly given that some changes undertaken in response to the pandemic will be temporary in nature. However, a NEL wide piece of detailed demand and capacity modelling work will be required to fully understand the precise nature of the planned service moves and the implications for WX and for the other acute hospitals in the ICS.

4.3 Hospital design

The impact of COVID changes some of the key considerations for the design of the hospital building itself.

The HCSS is primarily a clinical strategy document and therefore it does not provide a detailed design of the new hospital site. However, the models of care outlined in the HCSS do have implications for the design of the hospital, and the HCSS does summarise some principles for the hospital design:

- Replacement of the old nightingale wards and expanding the number of single rooms
- The expansion of space at the 'front door' will allow for greater cross-disciplinary working in the SDEC model
- Co-locating services more effectively, such as locating diagnostic services near to ED will improve patient flow
- Redesigning outpatients will allow for greater flexibility in the type of clinics delivered

As described earlier in this document, the models of care in the HCSS will be updated due to the impact of COVID and this will alter some of the key considerations for the design of the hospital building. These changes include:

1. **A reconfiguration of the front door**. We anticipate that the future model of emergency care will mean that fewer patients will 'walk in' to ED. Instead patients will be referred directly into different emergency services within the hospital (i.e. ED, SDEC). The relative location of these services is to be determined.

2. **A smaller outpatient area** with dedicated private space to conduct virtual appointments. In the future, a higher proportion of outpatient consultations will be carried out virtually. Activity during the pandemic has provided proof of concept, and suggested that the proportion of virtual outpatient clinics could be higher than previously thought possible. The space required for outpatients will thus be different, with fewer face-to-face consultation rooms, smaller waiting areas and more dedicated private space for virtual consultations.

3. **A different space requirement for diagnostics and imaging on the hospital site**. The pandemic has shown the importance of being able to get diagnostic results as quickly as possible to understand whether a patient is COVID positive or negative. This has emphasised the importance of point of care testing, and the need for diagnostic equipment as close to

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the patient as possible to avoid inefficiencies of transporting samples. Where diagnostics cannot be carried out at the bedside, Infection Prevention and Control guidance may necessitate separate diagnostic facilities, however, the most efficient co-location of services on site is yet to be determined.

COVID has exposed the challenge of managing infection control in hospitals and a future hospital design needs to be future proofed for future pandemics and other similar impacts:

1. **An increased number of single rooms/ side rooms** would improve infection control and reduce nosocomial infections on the wards and in waiting areas – there may be national guidance which determines the minimum proportion of single rooms for new hospitals.

2. **An increased flexibility in the organisation of wards**:
   a. This would allow wards to be easily repurposed as circumstances dictate, for example, a medical ward could be used as a critical care ward if there was a need to rapidly step up further critical care capacity.
   b. This would provide the ability to isolate wards effectively by blocking off areas, for example to separate elective and non-elective patients, staff and facilities.

3. **An increased number of entrances to the hospital.** Previously, the aim was to reduce the number of entrances to Whipps Cross, in order to make access to the site simpler for patients. However, multiple entrances enables streaming of patients, visitors and staff through the site to the appropriate COVID or non-COVID areas. This would shield and protect vulnerable groups and prevent crossover between certain areas of the hospital (for example elective patients who have tested negative for COVID-19, and non-elective patients who may be carrying the virus).

4.4 System working

The HCSS is a strategy for the hospital but it has clear interdependencies with the implementation of the Waltham Forest out of hospital strategy.

The model of transformed and innovative hospital care set out in the HCSS is dependent on system-wide efforts to drive an integrated community-based care and prevention agenda as per the NHS Long Term Plan. The HCSS sets out at a high level the holistic health and care model that hospital-based care sits within, and the models of care in the community that are critically interdependent with the hospital strategy. These are:

1. **Health promotion and wellness:** Delivering preventative and personalised care, assisting with lifestyle and chronic disease management
2. **Home/community based preventative care:** Identifying people with complex needs and long term conditions and enrolling them with a community MDT
3. **Discharge support in the community:** Rapid discharge from hospital supported by an MDT within the community

In order to deliver the models of care described in the HCSS as effectively and efficiently as possible, a shift in ways of working will be required across the system, including:

- Using specialist expertise across the system, for example, consultant advice to GPs or MDT advice on the wards
- Developing community multi-disciplinary teams that are well-connected to the hospital, with clear criteria and guidelines for escalation of issues

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- Improving mental health provision and further integration with physical health
- Ensuring support services, such as mental health liaison, are available 24/7 to the Emergency Department

The COVID pandemic has not fundamentally changed these requirements. However, there are elements of the strategy, particularly the models of care, that require further consideration in terms of assessing what has been delivered over the COVID period and what the ambition going forward should be as a result. The scale of the immediate requirement for the system is more clearly delineated as a result of COVID, given the ongoing impact of the IPC guidance on local bed provision and the requirement to plan for future COVID peaks.

Over the COVID period, we have seen a transformation in partnership working in order to minimise hospital stays. Hospital and community teams have worked collaboratively to implement the discharge to assess model through a discharge hub in the community with links to ward teams. This has improved the rate of discharge from the hospital. Community bed capacity was increased to support discharge from hospital, and the provision of services in the community was expanded through NHS 111 and home monitoring services.

In light of these initiatives and new guidance, there will be enduring changes to ways of working between organisation in health and care systems. Guidance says that the ICS will become the primary vehicle for the design and delivery of health and care, emphasising the need for collaborative working between organisations in the system. At a more operational level, discharge teams and MDT working in the community will continue to be strengthened, community bed capacity will be expanded and the model of support to care homes will be improved.

The initial elements of the partnership working described in the HCSS will not require fundamental change. However, there is the need to expand on the system elements of the strategy considering the transformation that has been accelerated through COVID and the recent planning guidance.

Some of the transformation work achieved over the COVID period will be sustained, some of which was not explicitly part of the original strategy. For example the expansion of NHS 111, home monitoring and other primary care services, and the increased community bed capacity.

Moving forwards, the Whipps Cross redevelopment will ensure firm links to Waltham Forest, Redbridge and West Essex.

4.5 Enablers

The models of care outlined in the HCSS are reliant on certain enablers:

- Effective technological support and sharing of information between teams and partner organisations
- Sustainable, multi-disciplined and integrated workforce
- An estate which enables new ways of working
- Aligned financial incentives which support innovation and transformation
- Rapid availability of diagnostics and interpretation of tests

While the enablers originally outlined in the HCSS are still necessary, there are certain additional features and requirements which have become evident as a result of COVID.

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1. **Workforce:** As a result of the pandemic, the normal volume of activity seen in the hospital has changed. For example, there has been a permanent increase in critical care beds and as elective services will need to work off backlogs, both to reduce the pre-COVID PTL to an ideal list size, and to catch up on missed activity. As a result, there is a need to understand the size of the workforce required to deliver these services, and the accompanying recruitment and retention programmes. The workforce model must be sustainable to stand up to future COVID peaks, with staffing ratios that can flex accordingly, and to allow efficient deployment of staff to maintain effective Infection Prevention and Control, where staff cannot cross between COVID and non-COVID areas. Furthermore, there will be changes to the ways of working. Workforce collaboration will be fundamental to delivering the successful consolidation of some services across NEL. Job plans and rotas will need to enable transformation (e.g. delivery of virtual consultations and hot clinics) and to allow hospital staff to work across care settings – both in the acute and to provide more support to community services. Additionally, staff are likely to work more flexibly, working remotely to deliver both clinical and non-clinical services.

2. **Digital:** Continuing to deliver more patient care through virtual consultations and facilitating increased remote working will require the right infrastructure to be in place. This includes implementation of the technology to deliver virtual patient care as well underpinning Wi-Fi networks.

3. **Communications:** Hospitals have seen significant changes to patient behaviour in recent months, both as a result of fear of attending hospital and of the public health measures. As these measures are relaxed, it may lead to a return to previous patterns of behaviour. Clear communications will be imperative to inform residents and patients about how services will change, how these changes will benefit them, and how they should access services going forward. Communications will need to be reflective of wider changes in NEL, across London and nationally.

4. **Patient transfer system:** During the pandemic, Barts Health sites worked closely to manage the volume of patients. Going forwards, there is a need for a sophisticated and digital patient transfer system to support movement of patients between sites, particularly for ventilated patients requiring transfer between critical care units.

5 Conclusion

In conclusion, this review indicates the HCSS remains the right strategy to underpin the redevelopment of Whipps Cross Hospital. There are however some areas of uncertainty which require further work to resolve. The crucial further line of enquiry is:

- The Emergency Front Door model will need to be revised to account for the development of the 'Help Us Help You' initiative

Much of the planning and implementation of the HCSS is underway – the divisions within the hospital are already leading much of the transformation work required. A delivery architecture has been set up for the programme to ensure that existing plans are aligned to the strategic direction of the HCSS. It is through this structure, which includes links to the Barts Health Clinical Boards, that the further lines of enquiry will be closed.

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This programme structure fits into the existing governance structure for the hospital redevelopment with the HCSS Steering Group reporting into the Whipps Cross Redevelopment Programme Executive and the Whipps Cross Strategic Partnership Board.

The programme will continue to learn from the pandemic. As it develops, there will be more evidence and input to be considered which may impact the future of the hospital in terms of models of care, scale of services and hospital design. The programme structure is set up to incorporate further input as we learn more about the long term impact of the pandemic. In particular this will be facilitated through the links to the Trust Clinical Boards who are leading the clinical response to COVID at a Trust level.

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