Royal Free London
Towards a Group Model for our health and care system

Sir David Sloman, CEO, Royal Free London

Eighth annual leadership and management summit
Transforming the future of health and social care

Thursday 10 May, The King’s Fund
### Our challenge as a system

#### The Question
Can we collectively prove a new model for acute provision which could be part of a national rollout to reliably deliver top right hand corner performance?

#### The Prize
Outstanding quality for patients and value for taxpayers

= best in NHS quality with >£5BN step-change reduction in real annual costs of acute sector

<table>
<thead>
<tr>
<th>Quality = CQC Rating</th>
<th>Reference Cost Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outstanding</td>
<td>0.0% 39.3% 48.9% 6.7%</td>
</tr>
<tr>
<td>Good</td>
<td>2.2% 10.4% 17.0% 3.0%</td>
</tr>
<tr>
<td>Requires Improvement</td>
<td>3.0% 21.5% 25.9% 3.7%</td>
</tr>
<tr>
<td>Inadequate</td>
<td>0.0% 6.7% 2.2% 0.0%</td>
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Cost Position = Reference Cost Index

135 acute (non-specialist) trusts covering costs of £48.9BN in 2015/16: latest CQC rating; %s show proportion of 135 acute trusts in each segment – contains rounding errors
RFL progress and ambition

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Quality = CQC Rating
Outstanding
0.0% 0.7% 3.7% 0.0%
Good
2.2% 10.4% 17.0% 3.0%
Requires Improvement
3.0%
England (ex. London)

Inadequate
0.0% 6.7% 2.2% 0.0%

Cost Position = Reference Cost Index

world class expertise local care

135 acute (non-specialist) trusts covering costs of £48.9BN in 2015/16: latest CQC rating; %s show proportion of 135 acute trusts in each segment – contains rounding errors

Royal Free London NHS Foundation Trust
8 requirements of a “top right hand corner” model

1. **Depth over breadth in specialist services** and academic healthcare

2. Horizontal partnerships and **population-level scale in local hospital services**

3. Quality improvement as the core motivation and **reducing variation in clinical processes** as the core process for implementing best practice

4. **Vertical integration across health and social care** to radically shift the focus of investment and intervention towards prevention and out of hospital care

5. Scale and the **benefits of critical mass in “back office”** corporate support services

6. Scale and the **benefits of critical mass in “middle office”** clinical support services

7. Major **non-treasury revenue streams** which can be reinvested for NHS benefit

8. A **clinically-led leadership model** capable of engaging clinicians to be in the driving seat of change, with sufficient capacity for delivery and able to grow the pipeline of future CEOs
Fragmentation in our health and care system

Top Issues

- ✗ High degrees of variation in patient care
- ✗ Multiple handover and coordination issues
- ✗ Lack of investment in prevention and out of hospital care
- ✗ Unexploited opportunities from digital innovation
- ✗ Limited career development routes for clinical leaders
- ✗ Duplication & low critical mass in clinical support services
- ✗ Duplication & low critical mass in corporate support services
- ✗ Minimal patient and taxpayer benefits from contracting architecture
Blueprint for a collaborative local health and care system

Clinically-led Whole System Pathways; Digital Innovation; Continuous Improvement

Hospital 1
- Patient Care

Hospital 2
- Patient Care

Hospital 3
- Patient Care

Mental Health
- Patient Care

Primary Care
- Patient Care

Community Care
- Patient Care

Social Care
- Patient Care

Clinical Support
- Pathology
- Pharmacy
- Imaging
- Endoscopy
- Other Diagnostics
- Private Patients

Corporate Support
- Payroll
- Bank & Agency
- IT
- Analytics
- Recruitment and HR
- Other Corporate Support

Single provider system able to be commissioned and funded on a population health basis
“Back office” – the benefits of critical mass

NCL procurement pooled (ex UCLH) and managed by the Whittington

Corporate support services relocated from RFL hospitals to Enfield

Next phase: automation…

12% reduction in WTEs through consolidation

Procurement Costs: £000s 2016/17
- Moorfields: £4.9M
- Great Ormond Street: £11.9M
- Royal Free London: £4.9M
- Whittington: £11.9M

Procurement Savings:
- Moorfields
- Great Ormond Street
- Royal Free London
- Whittington

Enfield Civic Centre
Chase Farm Hospital
North Middlesex
Barnet Hospital
North Middlesex

12% reduction in WTEs through consolidation

Next phase: automation…
“Middle office” – pathology services development

RFL as customer
- 8 million tests per annum
- Expected reduction in cost per test of c2%
- Demand management focus

RFL as investor
- 24.5% shareholding and £12M capital investment
- 2 Directors; “Red Line” items
- 9 months to June ‘17 profit ahead of plan
- Forecast return on equity over ten year life of contract on track

Create central capacity and capability
- Joint venture between Sonic, UCLH and RFL
- 800 scientific and administrative staff
- TDL UK track record
- Global purchasing capability and scale

Add customers and grow scale
- Initially RFH & UCLH
- NMUH since 2016
- BCF in procurement
- Ready for other bids

Build site-based out-reach
- New facilities (c. £40 million programme)
- Halo building (8,500 sqm)
- Largest laboratory IT team in the UK

Invest to cut costs and increase quality
- RRL at RF (Dec 2015), then NMUH (June 2016)
- 60 Whitfield St (UCLH’s RRL)
- RRL for new customers

• Joint venture between Sonic, UCLH and RFL
• 800 scientific and administrative staff
• TDL UK track record
• Global purchasing capability and scale
### “Middle office” – other developments underway

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<thead>
<tr>
<th></th>
<th>Create central capacity and capability</th>
<th>Create site-based outreach</th>
<th>Invest with others in capital to cut costs &amp; increase quality</th>
<th>Add customers and grow scale</th>
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<tbody>
<tr>
<td><strong>Pathology</strong></td>
<td>HSL JV with UCLH and Sonic Staff transfers (TUPE)</td>
<td>RRLs at RFH and NMUH RRL at Barnet RRL at UCLH (Whitfield St)</td>
<td>Halo building</td>
<td>NMUH BCF Other tenders</td>
</tr>
<tr>
<td><strong>Decontamination</strong></td>
<td>Offer on site in Enfield Build out</td>
<td>Transfer site-based activity from RFH, BH and CFH/re-use space for clinical services</td>
<td>New equipment and technology</td>
<td>Potential customers in NCL</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>Standardise medicines management &amp; optimisation</td>
<td>Local inpatient dispensing maintained on sites</td>
<td>Reviewing outpatient dispensing &amp; TTA options</td>
<td>Potential homecare hub development</td>
</tr>
<tr>
<td><strong>Imaging</strong></td>
<td>Centralise complex services (nuclear med, interventional rad)</td>
<td>Locally managed imaging services core to service delivery</td>
<td>Group asset renewal options appraisal</td>
<td>Radiology network North London Diagnostic Hub</td>
</tr>
<tr>
<td><strong>Endoscopy</strong></td>
<td>Diagnostic endoscopy - manage demand and waiting list at scale from CF</td>
<td>Local site endoscopy linked to Gastroenterology</td>
<td>Future radical solutions on outsourcing, asset renewal etc.</td>
<td>NMUH service operating from CF North London Diagnostic Hub</td>
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Reducing unwarranted variation in care quality and costs

2012-2016:
bottom-up learning

- Learning by doing: sepsis (as below), falls
- Positives: demand-driven and clinician-led; learning our own QI methodology
- Negatives: pace and support (e.g., project management, data and analytics)
- Learning from Intermountain

<table>
<thead>
<tr>
<th>Month</th>
<th>Percent Compliance with Severe Sepsis Bundle</th>
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<tbody>
<tr>
<td>2012</td>
<td>90.00</td>
</tr>
<tr>
<td>2013</td>
<td>85.00</td>
</tr>
<tr>
<td>2014</td>
<td>80.00</td>
</tr>
<tr>
<td>2015</td>
<td>75.00</td>
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2016 onwards:
top-down and bottom-up

- Retaining key positives of approach to date: clinical engagement and leadership
- Targeted infrastructure support organised as Clinical Practice Groups (CPGs)
- Working on over 30 hospital pathways since 2017
- Partnering with IHI on embedding Quality Improvement (QI) methodology
- Richard Bohmer leadership development courses and clinical academy
Reducing unwarranted variation – CPGs impact so far

### Induction of Labour Pathway

Out-patient induction rate via Cooke’s balloon for low risk cases (35% of all induction of labour)

Cooke’s balloon suitable for 1,190 cases p.a. with yearly saving of £350,000

<table>
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<th>Method</th>
<th>“Propess”</th>
<th>“Cooke’s balloon”</th>
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<td>Process</td>
<td>Inserted on ward with approx. 1-3 days in-Pt stay</td>
<td>Inserted on day unit, discharged to return next day</td>
</tr>
<tr>
<td>Cost</td>
<td>Approximately £326 (avg. 2 nights stay)</td>
<td>£20</td>
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### Teledermatology

-Launched Teledermatology for single skin lesions using a medical photographer based in the community

-50-60% back to GP & 15-20% directly for surgery (65-80% saving first O/P)

-Graph showing referral breakdown from December 2016 to June 2017

### Cholecystectomy

Reduce unwarranted variation in the management of Cholecystitis and address high variation in cost per patient.

-Implemented a one stop shop clinic. Standardised pathway so all patients had a ultrasound. Separated simple, complex, planned and unplanned patients to minimise length of stay appropriately

-Total cost of delivering the specified parts of the service fall from £4.24m to £3.78m saving £460,000 per year

-Savings from reduced overall activity through earlier use of definitive treatments, reduction in post operative follow up, reduction in A&E attendances, and reduced Length of Stay.
A set of Hospital Units with devolved accountability for day-to-day operations managed through Local Executive Teams comprising: Chief Executive, Medical Director, Nursing Director, Operations Director and Finance Director

A small Group Centre responsible for:
- Governing the hospital units
- Strategic decision making
- Setting Group-wide best practice policies, processes, standards and procedures (clinical and non-clinical)

Clinical Practice Groups (CPGs) setting clinical standards and ensuring hospitals are implementing them to reduce unwarranted variation

Group services that the hospital units (and non-Members) use on a charged-for basis; these cover those clinical and non-clinical services which benefit from scale
Clare Panniker
Group Chief Executive

Mid Essex Hospital Services NHS Trust
Southend University Hospital NHS Foundation Trust
Basildon & Thurrock University Hospital NHS Foundation Trust
The Mid & South Essex system - key facts

1. Travel times without traffic from Google Maps (Jan 16)
2. Population based on October 2015
3. HES data 2015/16
4. Based on 2015/16 data from SUH (highest A&E data quality of the three trusts)
5. Trust estates team
6. Health Education England Workforce Intelligence 08/16
7. STP submission October 2016

- SR population served by 3 local authorities, 5 CCGs, 3 acute trusts, and EEAST
- ~850 Daily A&E attendances
- ~5% Proportion of A&E attendances with nothing abnormal detected
- ~1800 Daily in-patient bed capacity requirements across the patch
- 16K NHS workforce in the SR
- >600 Number of GPs serving the region
- £100M 2015/16 system deficit
context and dynamics

1. **Unsustainable services**
   Mid and south Essex is an area with significant clinical and financial sustainability problems, leading to being placed within one of the ‘success regime’ areas.

2. **Poor relationships and lack of joined up thinking**
   The sustainability issues were underpinned by a lack of strategic leadership and poor relationships across the system (including, at the time, the acute sector).

3. **Structural issues**
   It was identified that a key barrier to making progress on previous acute configuration changes was the ‘independence’ of each acute trust / foundation trust making decisions involving win/lose changes not being made.
Remain as is, delegating maximum authority to a new sub-committee as agreed through a CJV agreement which meets in common as the joint working board.

Formed of the three board sub-committees meeting in common, membership of joint executive group, chairs and 2 further non-executives from each board.

New single executive team which is common to each of the three boards, responsible for driving strategic cross organisational change.

Responsible for day to day delivery, led by a Managing Director with each site director having accountability to both the Managing Director, and a relevant JEG member.
group working has brought the system together

**MSB aim May 2017:**

*To enable and implement the redesign of key pathways and reconfigure clinical services (subject always to commissioner engagement and consultation duties) with a view to improving care by moving care out of the hospital and closer to home, greater use of technology and self-care and reduction in routine follow-up in outpatients.*

**November 2017:**

Agreement of a single long-term acute clinical strategy across the msb group –not possible as single organisations due to impacts on single trusts of reconfiguration.

Unified acute services model for STP which provides an opportunity to stabilise and sustain the three local hospitals, improve quality and access for patients.
16-week public consultation
Clinical leadership across 3 trusts
Meaningful public engagement

Addressing workforce challenges
Centralising for outcomes
Sustaining high-quality local services, including emergency care

Mid and South Essex Sustainability and Transformation Partnership (STP)

Your care in the best place
At home, in your community and in our hospitals
Public consultation 30 November 2017 to 9 March 2018
www.nhsmidandsouthsussex.co.uk
group helps sustain local services and support integrated care

**Sustainability**

- Benefits of EDs working together across our three local trusts: vacancy factor for consultants more than halved since 2016.
- Seen improved recruitment where teams work together e.g. Radiology.
- Movement of patients and expanded choice between trust sites to facilitate better use of equipment (e.g. robotics) and improved waiting times.

**Local care**

- Benefits of local sites working in system with local authorities, commissioners and GPs.
- Integrated medical centres on the high street; joint projects e.g. schools, housing.
- Improved discharge, STP “winter room”; new model of hospital at home.
Leading change is core business

1. **Clinical redesign and reconfiguration**
   Standardisation and ‘levelling up’ of clinical services and pathways, leading to clinical service reconfiguration (i.e. specialist emergency centre designation).

2. **Clinical and corporate support**
   Three to one consolidation and levelling up of services, leading to fundamental service transformation through partnerships, use of technology.

3. **Site programmes**
   Continuous improvement of existing service delivery, focus on core quality, operational and financial controls to deliver business as usual improvement.

4. **Strategic projects**
   Focus on whole system integration, innovation and exploiting commercial opportunities.
delivering change: institute.

01 Equipping
Our people to make changes and giving them the skills to improve their job, team and service.

Future ready and change positive people
It is our ambition to equip our people with the skills they need to be able to make changes to improve their services and the clinical skills they need so that they are ready for new service models.

We will lead the development of a new approach to workforce supply, including the support required to strengthen leadership and create the leaders of tomorrow.

02 Enabling
Systematic and systemic approaches to improvement, delivering better outcomes.

Creating 21st century services
We will develop and implement a systematic and systemic approach to improvement and project delivery which can be tailored to support the development of new pathways of care at both local and regional level.

03 Supporting
Our people through change, developing and sharing best practice and innovation.

Supporting innovation, driving best practice
Our change managers will support individuals and teams through change and help secure the benefits of this change for patients and the communities we serve.

We will work across the health system and with academic and industry partners to gather to develop and share best practice and act as an incubator for innovation in service delivery and new ways of working.
Group has limitations, disincentives and barriers in current system

- Options appraisal process with Boards and key stakeholders of the three local trusts recommended 3-way merger as best way forward to work together, process began January 2018.

- Merger of equals, to enable change and bring us closer together.

- To provide the best services for our patients we need to have the right systems and processes and make the most of the resources, skills and expertise we have across our trusts.

- We are doing much of this together in similar ways now, but removing duplication, perverse incentives and transactional barriers through organisational form will help accelerate progress and any future implementation.
Thank you

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