NHS

Closer collaboration

How Barking, Havering and Redbridge University Hospitals and Barts Health are working together to improve services for their patients

Our main locations

Mile End Hospital

Whipps Cross Hospital

King George Hospital

Queen's Hospital

St Bartholomew's Hospital

The Royal London Hospital

Newham Hospital

Barking Community Hospital

- Barking, Havering and Redbridge University Hospitals NHS Trust
- Barts Health NHS Trust
- NHS site hosting some BHRUT services

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Foreword from our chief executives

The welfare of patients is at the heart of the NHS, and we are all committed to maintaining and improving the quality of care. This is not just medical treatment but how people are looked after in every aspect of their care – literally, how patients are treated, in and out of hospital. We learned a lot of unexpected lessons about how we work during the course of the pandemic, and one of them is the value to patients of collaborating across professional and organisational boundaries.

The NHS was founded in this spirit of co-operation, and working together for the benefit of patients is a cornerstone of the NHS Constitution. The pandemic brought to life examples of how we could better put these values into practice. Across north east London, we are all working much more closely with our NHS and local authority partners than ever before, from co-ordinating provision of critical care beds and medical supplies, through managing demand for urgent and emergency care, to improving discharge arrangements from hospital to the community. The outcome is already a better deal for patients – quicker, appropriate and convenient treatment.

So why stop here? It makes sense to explore all the potential benefits of closer collaboration between neighbouring organisations. We listened to staff and stakeholders about how the Barts Health group and Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) could work more closely together for the benefit of patients across our joint catchment area. Our journey is in line with the strategic direction of travel towards more integrated care in the NHS as a whole, and many other hospital trusts in London and elsewhere are developing similar models. Both trusts will of course continue to collaborate in various ways with Homerton University Hospital NHS Foundation Trust.

This document sets out what we have done so far, and how we propose to go forward as separate NHS Trusts under a new chair in common, Jacqui Smith. There is much still to discuss, but on the basis of what we have learned so far we believe there is much to be gained, especially in the context of population growth – the equivalent of a new borough in a decade – that will affect both organisations equally.

This is not just about two trusts working in tandem, but about how our collaboration benefits the seven boroughs our hospitals serve. We are engaging with partners in each of our local authorities to develop integrated place-based partnerships that tackle health inequalities and improve health outcomes. We see each of our hospitals growing a key role as anchor institutions within local communities, providing a variety of jobs for local people and purchasing goods locally, as well as providing vital NHS services to patients alongside GPs and community partners.

Dame Alwen Williams
Group Chief Executive,
Barts Health NHS Trust

Matthew Trainer
Chief Executive,
Barking, Havering and Redbridge
University Hospitals NHS Trust

Origins: **Why are we doing this?**

The ethos of the NHS has always been about working with others to help those in need. The scale and speed with which the Covid-19 pandemic took hold in 2020 brought home the importance of this fundamental truth. The country rallied round to protect the NHS as the best guarantor of public health and safety. Across our national health service, staff dropped their residual organisational loyalties and put aside any lingering personal or professional prejudices to fight an unknown and unprecedented threat to the nation's wellbeing.

Within north east London, clinicians and managers came together to sort out one particularly pressing need – the urgent requirement for extra critical care beds. The nature of the coronavirus as an infectious respiratory disease meant that every hospital needed more, with ventilators, and quickly. Our local integrated care system needed more than double the number available. With our partners among local providers, we set up a critical care hub to monitor daily demand, co-ordinate capacity requirements, and enable patients to be moved to the best available clinical environment for their needs. It proved remarkably successful in each successive phase of the pandemic, and demonstrated the practical value of closer collaboration.

As the pandemic progressed, we found ourselves working ever more closely with our partners in the local health system on a range of other issues. An urgent and emergency care hub soon followed, in time to ensure we could all prepare for winter with Covid-19. We further co-operated to ensure sufficient oxygen supplies reached each acute hospital; to distribute adequate quantities of Personal Protective Equipment for staff; and to facilitate the prompt and appropriate discharge of treated patients from hospital. The principle of mutual aid is now well established across north east London. It now forms the basis of an ongoing understanding between the two largest providers in the area, the Barts Health group (BHG) and the Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT).

These developments were not entirely novel, as over the last decade the NHS in London pioneered the principle of cross-system working though the creation of both a cancer alliance for the capital, and a stroke network. The north east London cancer alliance currently has the best performance in the country (with 80% of urgent cases referred to treatment within 62 days). The Early Diagnosis Centre which opened last year at Mile End hospital is another joint venture (involving Homerton as well as BHG and BHRUT), and will carry out 16,500 procedures annually on those living with conditions that increase the risk of cancer.

Closer collaboration between providers also makes it easier to deliver mutual aid at scale. The BH group already provides the biggest share of acute activity in north east London, and in some specialities is the sole provider (eg children's surgery, major trauma, renal transplantation, cardiothoracic and some cancer surgery). The waiting times lengthened considerably due to Covid-19, and to reduce them as rapidly as possible they looked for support from local hospitals with shorter waiting times. Yet even before the pandemic there was a growing recognition that a broader approach could ensure the more efficient provision of greater numbers of routine operations with optimal safety. Hence the six surgical specialities with the biggest waiting lists in north east London are now benefitting from the creation of high-volume low-complexity hubs; in all six specialities at King George Hospital (KGH), in three at Whipps Cross, and in one at Newham.

As this was happening, the trend in national policy moved from fostering competition among providers towards facilitating greater collaboration. As part of the wider development of integrated care systems, NHS guidance set out three principal benefits of collaboration:

- Reducing unwarranted variation in outcomes and access to services
- Reducing health inequalities
- Increasing resilience across health system, through mutual aid, managing capacity, and alleviating workforce pressure

Meanwhile NHS England is actively encouraging neighbouring trusts to co-operate closely, and a number have already adopted joint chairs and even joint chief executives. When Ian Peters, the Barts Health chair, announced he was stepping down to take on a national role, the Trust and BHRUT agreed that his successor should be a chair in common. The new post was advertised nationally in the expectation that the successful candidate would take forward a process of closer collaboration. In anticipation, the two Trusts embarked on an inquiry to further explore with staff and stakeholders the options and opportunities for more joint or integrated working.

Case study: **Creating a critical care hub**

The sudden arrival of Covid-19 brought people together across the NHS because the coronavirus was unknown, mortality was high, and hospitals didn't have enough critical care beds for the growing numbers of sick people. This common predicament sparked a wider recognition of the value of working across organisational boundaries. In particular, by sharing supplies and managing patient flow across a bigger footprint, we could ensure smaller hospitals did not get overwhelmed.

Rajesh Jain,
Critical care lead at BHRUT, said:

"We started working more closely with Barts Health - and other partners across north east London - at the start of the pandemic. There was a huge amount of mutual support. We had daily calls, twice daily during the peaks; at such an uncertain and challenging time, these helped us realise we weren't on our own. Our co-ordinated effort meant we could work much more effectively, and safely, for our patients.

During our busiest times in the second wave, we were able to send patients to other hospitals, and in times when we had more capacity, we were able to accept them from elsewhere. I now know colleagues I'd never met before by their first names, which is a great thing as it means we don't hesitate to get in touch when we need help. We even set up the obligatory WhatsApp group!

Working in partnership worked so well it absolutely should continue, and we should be looking at other areas where it could benefit our patients."

Charlotte Hopkins,
Group deputy chief medical officer at Barts Health, said:

"There is always a healthy professional rivalry between clinicians in different organisations, but if we say we are in trouble we rally round. We were scared about what was going on in the world - I had people in my office in tears, worrying. I had telephone conversations with colleagues in Homerton and at BHRUT I had never met before. They joined our daily conference call within Barts Health – MS Teams didn't exist then – and we rotated the chair between us. It was all about sharing information and ensuring voices were heard, but the outcome was that a group of clinicians controlled patient flow and managed mutual aid across multiple critical care units. Together we ensured an unprecedented number of patients with severe respiratory disease got the immediate treatment they needed."

Lessons: What have we learned so far?

We took an approach to change that seeks to build on what works well in order to identify opportunities. This combined elements of both engagement and fact-finding, enabling us to listen to the views of staff and stakeholders to test the appetite for closer collaboration, while also establishing the full extent of what was already happening. During May and June we conducted more than 100 individual interviews, hosted a number of group discussions, and surveyed the views of over 1,550 interested staff.

The process was necessarily limited in scope, because at that early stage we did not want to raise expectations that might not be realised. Nevertheless, the inquiry tapped into support for the principle of closer working and a willingness to find out more. We found some informal collaboration was already taking place, amid a clear recognition that the combined scale of the two organisations could create a powerful lever for progress in key areas.

A common view was the importance of stable leadership teams, with senor clinical and executive oversight to give authority to a shared agenda. This would require expression in settled governance and transparent decision-making. Some suggested an overarching structure might ensure the best outcomes between trusts and hospitals during the early stages of collaboration. And we heard about the value of consistent reporting of performance and having comparable standards of clinical assurance and quality governance.

Colleagues also highlighted the need to make good on the commitment and energy shown to date from clinicians and managers, and secure similar goodwill from across all staff groups. Any changes would need to be made in ways that minimised disruption in our hospitals and reduced the risk of adverse reaction. Collaboration would work best by aligning our approaches to quality improvement methodologies, so that we learned from the best within each organisation and adopted the same approach to transformation.

Another aspect would be the potential for staff to move more freely across hospitals. The prize here would be the opportunity for individuals to gain broader experience and develop skills for personal development, and the scope for the organisations to attract or retain talent. However, embracing this option would involve upgrading back-office and information systems, and working on developing a future joint workforce through shared recruitment practices.

Meanwhile, we found further evidence that closer collaboration was already happening organically at a local level between departments. Building on the pandemic initiatives already outlined, each Trust is routinely allowing its patients access to the other's facilities, including specialist capacity. For example, we have just agreed a new pathway for endoscopy under which some Barts Health patients will transfer to KGH. More than 300 referrals from Whipps Cross since June have reduced the backlog of patients waiting for such examinations by one-tenth. Meanwhile, in planning a joint network of community diagnostic hubs, BHRUT offered to allocate half the extra imaging capacity that is being commissioned at Barking Hospital for Barts Health patients.

We are further developing existing joint networks across specialties, such as cardiology and maternity, and more recently, vascular and neurosurgery. For example, eight consultant cardiologists are working across both Trusts, effectively as joint appointments. This will mean patients receive better care, more quickly and can access specialist cover when needed. We are also learning from each other about how to solve shared challenges, such as operational performance. Karim Ahmad was seconded from Barts Health to be medical improvement director for emergency care at BHRUT and help the A&E teams tackle levels of demand as high as during the winter of 2019. BHRUT is sharing learning from its successful initiatives to improve productivity, while Barts Health is sharing its analysis of waiting lists to reduce inequalities.

The pandemic gave fresh impetus to this spirit of co-operation, and kick-started some significant new areas of collaboration. The challenge we face now is to maintain that momentum and embed it into our mutual task of recovery and transformation. One other lesson from the inquiry was a clear desire among our stakeholders for more local engagement and decision-making regarding the needs of their local populations. Partners wanted to see services building up locally rather than consolidating. They highlighted our need to respond to the local partnerships that will be responsible over time for delivering co-ordinated care.

Case study: **Collaboration in cardiology**

St Bartholomew's Hospital

King George Hospital

One inadvertent consequence of the national decision to suspend planned operations during the first pandemic peak was a growing backlog of patients awaiting treatment with complex devices at the Barts Heart Centre (BHC). Without timely medical intervention, these patients would be at risk of deteriorating heart failure or even sudden death. The Trust asked around the north London cardiac network and BHRUT offered the use of two unused but staffed catheter laboratory sessions at KGH.

With the support of the specialised commissioning unit at NHS England, the teams set up a complex device service from scratch within six weeks. This involved redrafting job plans for consultants from both Trusts, training cath lab nurses, radiologists and physiologists at BHRUT in new skills; transferring stock, and adopting the BHC standard operating procedure.

The first patient was treated in August 2020, and over the next 12 months a further 45 patients agreed to have implantable defibrillators or complex pacemakers fitted at KGH. Only one suffered a minor complication, which was successfully rectified at KGH; there were no deaths, overnight stays or unplanned hospital admissions. The patients collectively rated their experience as 4.97 out of 5, and everyone was treated within a few weeks, bar one who chose to wait longer.

Dr Fahad Farooqi,
Clinical Lead in Cardiology at BHRUT, said:

“This collaboration achieved its primary objective of restoring patient safety and ensuring patients were treated within an acceptable time frame. It also demonstrated it is possible to reproduce high quality standards of care at another site with good outcomes and excellent patient feedback. Based on this experience, BHRUT recruited an additional full-time consultant with specialist interest in complex devices, and now has capacity to undertake 80 complex implant procedures in a year.”

Challenges

Both our organisations face population-health challenges in north east London that are unique and demanding. Life expectancy is lower than the London average, and the majority of residents live fewer years in good health. They also grapple with some of the greatest levels of deprivation in the country. An estimated 425,000 local people live in poverty, well above the national average, and a quarter of them are children.

This population is growing rapidly. Over the next 10 years, an additional 250,000 people are expected to be living within the seven boroughs covered by BHG and BHRUT. By 2050, it is expected that minority ethnicities will make up 57% of the total population. The greatest growth across age bands is expected among the over-65s. People from minority ethnicities are already likely to experience poorer health outcomes, while an ageing population with complex needs will only pose greater demands on acute care.

Barts Health and BHRUT are major employers within north east London, with almost 15,900 and 7,500 whole-time staff respectively, most of whom live locally. Workforce costs account for two-thirds of turnover, with a history of persistent vacancy rates causing significant extra spend on temporary workers. Our staff are diverse, with 56% of BHG employees and 48% of BHRUT from Black and ethnic communities that are minorities elsewhere in the UK, compared to 21% nationally. Despite both organisations' commitments to inclusion, staff survey findings consistently highlight concerns about discrimination and inequality.

Both organisations therefore share a common interest in improving health outcomes and reducing health inequalities across our footprint. We both believe we can do this to the greater benefit of our staff, while simultaneously using our purchasing and employment power to boost local economic activity.

Both trusts face challenges in recruiting and retaining adequate workforce numbers, with the knock-on effect being the high costs of temporary staffing. We see opportunities to join forces to offer a greater range of training, more health and wellbeing support, and more varied career paths. For example, the BHG leadership academy could expand its offer to include BHRUT leaders, while in return BHRUT could extend its training opportunities for apprentices, radiologists and AHPs.

Urgent and emergency care is arguably the greatest point of operational pressure in the NHS, and we are no exception. Though demand from the public was suppressed during the pandemic peaks, it is growing once again, with people in need having to wait longer than expected for treatment in A&E. There are examples of excellence, such as the major trauma centre at The Royal London, and our ambition is to extend this sort of world-class clinical quality across our footprint. By working together more closely, systems and processes in daily use at our better performing sites can be applied elsewhere to help improve our collective performance.

Meanwhile the last 18 months saw a sharp increase in the number of people waiting for planned operations. The Barts Health backlog is particularly pronounced, although BHRUT achieved greater proportionate reductions over the short term in addressing some areas of the overall waiting list. To make further inroads into the waiting list we must scale up and share operational processes across our two trusts.

The medical and scientific evidence shows that high-volume specialist services provide the best outcomes for patients. So discussions are already underway about creating more centres of excellence for individual specialties or procedures. This would particularly benefit patients needing neurosurgery, vascular surgery, interventional radiology, and neuro radiology. Combining our expertise will allow both Trusts to attract talent, build excellent care, and make it available 24/7.

A similar principle can be applied to improving cancer care. Although we both provide prompt treatment to those who are referred to our hospitals, the one-year survival rates in our boroughs is below the national average. By working together and linking with primary and community care, we could expand our capacity for early diagnosis and set patients up for the best chance of surviving cancer.

Across north east London, six of the seven boroughs have an acute hospital within the local authority boundary. The exception is Barking and Dagenham – but through joint working across our two organisations there is now an opportunity for patients in the borough to develop closer links with their nearest acute hospital at Newham. There is also scope to enhance the role of Barking Community Hospital as a diagnostic centre and gateway into the local health system.

As well as working together to drive immediate improvements in clinical services, there is clear potential for closer working across corporate functions, like HR, finance, business intelligence and estates.

Both organisations face continuing financial challenges, and consolidating expertise across them could increase operational efficiency and reduce the cost of bank and agency staffing. We could even work together in support of a joint financial recovery plan to address the underlying deficits. Through closer collaboration we could in time begin to redress some of the inequalities in the availability of resource availability. Over the past four years, Barts Health has been able to invest between three and seven times as much in capital spending as BHRUT.

We also see potential in jointly developing digital solutions to support patient care, such as through the use of Artificial Intelligence within diagnostics. Although the technology is still in its infancy, there is an opportunity to install the infrastructure that would allow new technologies to be seamlessly integrated into our clinical offering. Both organisations grapple with a legacy of underinvestment in informatics. We would need high levels of inter-operability in our clinical systems to make the most of many collaboration opportunities. Getting to a consistent baseline as soon as possible would prepare the ground for a long-term joint digital strategy.

Our approach to collaboration is necessarily dependent on the support of our local partners. The work of the North East London Integrated Care System (NEL ICS), of which we are part, is crucial in establishing place-based interventions, and putting in place balanced sector-wide finance and investment plans. Nothing that BHG and BHRUT do together should interfere with the joint working that already exists with Homerton in many clinical areas, and an important aspect of all our efforts will be working closely with the mental health providers covering north east London.

Case study: **Cancer collaboration**

Mile End Hospital

For many years Barts Health and BHRUT have sought to provide equitable cancer provision across the patch, most recently under the umbrella of the NEL London Cancer Alliance. Together the two Trusts manage the 62-day pathway for their patients, helping NEL deliver the best cancer performance in London.

The rapid diagnostic service centre at Mile End is staffed by both Trusts, currently offering endoscopy but with plans for ultrasound and MRI too. BHRUT sends most of its patients requiring PET scans to Barts Health but recently opened its own rapid diagnostic centre at KGH.

The group also supplies complex surgery for BHRUT patients referred with gynaecological, head and neck, hepatobiliary and lung cancers. Recently the Trusts agreed to join forces to create an integrated surgical neuro-oncology service, one of the largest in London.

Oncology teams from the two organisations worked closely together to deliver urgent cancer surgery during the pandemic, and Prof Tom Powles of Barts Health and Mr Joe Huang of BHRUT are exploring further collaboration in both medical research and developing common patient pathways.

Priorities: **Which areas are we taking forward?**

In the light of all these considerations, the two Trusts agreed an initial list of 12 priority areas for closer collaboration – some immediate to drive urgent improvements in clinical services; others facilitating ongoing joint initiatives; and a few more long-term shared endeavours. Over the next few months the organisations will work together to deliver measurable outcomes in each. This will involve identifying and connecting senior leads, tasking them with developing a programme, and providing appropriate resourcing and executive oversight.

a) Immediate

- Planned care recovery (including cancer). This could involve treating patients from the BH elective backlog at KGH, and making optimal use of diagnostic capacity at both Barking Community Hospital and Mile End. We would aim to improve elective access rates, demonstrate equity targets and achieve more efficient use of mutual assets.
- Improve delivery of urgent and emergency care performance, especially at Queen's and KGH. As well as better performance measures we would expect to see improved staff morale, retention and mutual knowledge-sharing.
- Recruiting and retaining staff through improving fill rates, reducing reliance on temporary staff, and accessing medical education. This would be measured through lower vacancy rates, reduced agency spend and feedback from Health Education England.
- Managing Covid and winter peak pressures, working with system partners to maximise joint resilience. This would enable us to manage demand for critical care, improve performance in urgent and emergency care, and increase the volume of elective work.
- Capacity planning for Barking & Dagenham, exploring service development at both Newham and Barking hospitals - potentially through a bid to the New Hospitals Programme - to effectively manage our joint assets.

b) Ongoing

- Specialised medicine: we will do a stocktake of existing collaboration in each specialty, with a view to adopting it into the collaborative programme (e.g. through integrated renal provision, or extending the respiratory network).
- Specialty developments (particularly in stroke, mechanical thrombectomy, neurosurgery, and vascular): again we will conduct a stocktake to bring any developments under the umbrella of the collaboration programme (e.g. the single stroke and thrombectomy pathway for north east London, or the integrated neurosurgical service).
- Maternity: strengthening clinical leadership at BHRUT and both trusts working with Homerton to implement the Ockenden recommendations.
- Corporate services collaboration already underway (e.g. shared procurement or back-office partnerships on business intelligence).
- Strategic financial planning, in the context of developing a NEL-wide ICS financial strategy.

c) Long-term

- Realising potential in research and clinical trials, particularly through improving enrolment rates.
- Digital alignment and strategy development.

Next steps

This report marks the conclusion of the initial scoping stage of our joint enterprise, and the start of a second phase to actively develop a shared approach in the 12 agreed priority areas. During the first phase we concluded that there are potential opportunities for our patients, staff and communities, and identified some worth pursuing. In the next phase we will take forward these immediate priorities. In doing so, the two organisations will continue to involve our staff and stakeholders in this exciting journey of closer collaboration, and publish updates where necessary.

Our new chair in common is Jacqui Smith, who arrives after eight years as chair of University Hospitals Birmingham NHS Foundation Trust. In that capacity she successfully steered closer clinical collaboration between two separate NHS trusts into a new operating model for the city. She takes up her new role in October with a personal commitment to support our emerging partnership for the benefit of all our patients. In particular, Jacqui intends to engage widely with stakeholders on the next steps, and consider what she can do as chair in common to take forward the collaboration under appropriate mutual governance arrangements.

During the summer, we also welcomed Matthew Trainer as the new substantive CEO for BHRUT, following a series of interim appointments. One of his chief objectives in the coming months is to stabilise the BHRUT senior leadership team by making a number other permanent executive appointments. With that in place we could move to establish appropriate joint executive governance for the collaboration.

As Jacqui and Matthew develop their new roles, both Trusts will continue to play leading roles in the ongoing work to create a fully integrated care system across north east London. We anticipate that these discussions will result in agreement on a joint Memorandum of Understanding with our partners in the NEL ICS. This could cover prospective programme outcomes, governance and resourcing.

TAKING PRIDE IN OUR CARE

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