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Health Partnerships Overview and Scrutiny Committee – Supplementary Agenda

Tuesday 7 February 2012 at 7.00 pm
Committee Rooms 1 and 2, Brent Town Hall, Forty Lane, Wembley, HA9 9HD

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Kabir (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Leaman	Ms Shaw
Beck	Clues	Cheese
Colwill	Baker	Kansagra
Daly	Ketan Sheth	Van Kalwala
Hector	Aden	Al-Ebadi
Ogunro	McLennan	Oladapo
RS Patel	Naheerathan	Oladapo

For further information contact: Toby Howes, Senior Democratic Services Officer 020 8937 1307, toby.howes@brent.gov.uk

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www.brent.gov.uk/committees

The press and public are welcome to attend this meeting

Supplementary Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

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Supplementary papers are attached.

Please remember to SWITCH OFF your mobile phone during the meeting.

- The meeting room is accessible by lift and seats will be provided for members of the public.
- Toilets are available on the second floor.
- Catering facilities can be found on the first floor near the Paul Daisley Hall.
- A public telephone is located in the foyer on the ground floor, opposite the Porters' Lodge

North West London

NHS North West London
Southside
105 Victoria Street
London, SW1E 6QT

Tel: 020 3350 8000

1 February 2012

Dear Councillor Kabir

***Shaping a healthier future* programme**

I'm writing to you to follow up formally on the briefing session you attended on the *Shaping a healthier future* programme on Monday 16th January.

The case for change which underpins *Shaping a healthier future* has now been published and a copy of this document is enclosed.

As we discussed on 16th January, the Case for Change highlights the challenges facing the current system and demonstrates that, despite recent improvements, significant service change is likely to be required to enable us to provide the quality of patient care that our clinicians aspire to. Over the next few months, we will continue conversations with local clinicians, local healthcare providers, patients and the public to identify the best possible solutions to address these challenges.

As we discussed during our briefing session, the consultation is likely to have specific proposals affecting your borough and therefore needs to be considered by your local Health Overview and Scrutiny Committees (HOSCs). However the proposals are very likely to cover issues that span multiple boroughs therefore there is a need to consider any proposals jointly through a Joint Health Overview and Scrutiny Committee (JHOSC). We have drafted the enclosed briefing paper which sets this out in more detail. The paper also covers the plans for the programme's pre-consultation engagement period and for public consultation.

We would be grateful if you could table this paper for discussion at your next Committee meeting. If you would like a programme representative to attend an upcoming meeting please do contact us to arrange this.

We will be in touch shortly with dates for the next joint meeting with all North West London HOSCs. In the meantime if you would like more information please phone 0800 881 5209, visit www.northwestlondon.nhs.uk/shapingahealthierfuture or email Lisa Anderton, lisa.anderton@nw.london.nhs.uk.

Kind regards,

Anne Rainsberry
Chief Executive, NHS North West London

cc
Ian Adams, Director of Communications, NHS North West London
Andrew Davies, Policy and Performance Officer

NHS

North West London

Shaping a Healthier Future
Health Overview and Scrutiny Committees Briefing Paper

1. Purpose

1.1 This paper sets out some further detail on the plans for engaging with Health Overview and Scrutiny Committees (HOSCs) in North West London (NWL) as part of the *Shaping a healthier future* programme for service change. The programme will affect around 2 million people across the eight NWL boroughs.

1.2 The paper includes a summary of initial discussions and key next steps. This includes:

- the process and intentions for engagement and decision-making with a joint HOSC (JHOSC), individual HOSCs and Health and Wellbeing Boards as well as other elected members and the wider stakeholder landscape;
- further detail on the Programme timeline including opportunities for engagement both at local and NW London-wide level;
- further detail on the intended parameters and content of the pre-consultation period and consultation itself; and
- a summary of the earlier informal briefing session and key points raised.

1.3 The paper is intended for consideration by individual Chairs and their Committees.

2. Background

2.1 NHS North West London wrote to the eight Local Authority Health Overview and Scrutiny Committee chairs and officers, as well as members of neighbouring boroughs, in December 2011. The letter set out the work that the NHS in NWL had begun, looking at possible service change and including the intention to formally consult the public in 2012.

2.2 Following this letter an informal briefing meeting was held on 16th January 2012.

2.3 The meeting was well attended. All eight North West London HOSCs were represented (Westminster and RBKC by officers only). Additionally, an officer from the London Borough of Richmond was in the room.

2.4 There was a presentation from Anne Rainsberry (Chief Executive, NHS NWL and Senior Responsible Officer for *Shaping a healthier future*), Dr Mark Spencer (Medical Director for NHS NWL and *Shaping a healthier future)* and Dr Tim Spicer (Hammersmith & Fulham GP Commissioning Consortium GP Lead) which gave an introduction to the Shaping a healthier future programme and an outline of the developing case for change. There was a good discussion though a number of common concerns were raised and this paper aims to address some of these.

2.5 A summary of the discussion and the key concerns is attached in Appendix 1 including a list of attendees.

2.6 At the briefing session it was agreed that the Case for Change would be shared once published and this has been circulated with this paper.

3. Content of pre-consultation engagement period and public consultation

3.1 The pre-consultation period (January – May 2012) will comprise detailed discussions with a broad range of local stakeholders, based on the Case for Change, about the development of service change options and the criteria we will use to evaluate them.

3.2 The main focus of this pre-consultation period will be two major engagement events; one on 15 February to which representatives from all local authorities, through the chief executive, have been invited and a second in March (23 March). This later event will look more specifically at the process of short-listing options for change.

3.3 We expect that this process of developing, appraising options for consultation will lead us to a shortlist of options (e.g. one to three options) to take to consultation; this will also be informed by the pre-consultation engagement.

3.4 Similarly, we currently expect to be ready to go to consultation in June for a minimum 12-week period. The start date is also subject to feedback received during the pre-consultation engagement period.

4. Process for engagement, scrutiny and decision-making with JHOSC, individual HOSCs and Health and Well-being Boards

4.1 It is clear that discussions with stakeholders take place now at both a local and more regional level and we expect this to continue. Local NHS leaders will continue to engage Local Authorities on a range of topics, especially those with joint commissioning arrangements and as part of the ongoing dialogue at shadow Health and Well-being Boards (HWBs).

4.2 As such, monthly briefing sessions will now be set up to ensure all HOSCs are briefed on programme progress and have an opportunity to feed in their views and input.

4.3 However, we wish to engage with JHOSC once option(s) for consultation are identified and in lead up to decision to go to consultation.

4.4 We would expect JHOSC members to take topics for discussion back to their respective committees; however, the JHOSC would hold sole, delegated authority to make comments on any proposals.

4.5 Although individual HOSCs will not have a formal role in this process (for reasons given in section 5 below) we will be glad to engage, in an informal and proportional way, local HOSCs that would welcome that extra involvement.

4.6 It is not intended that Health and Well-being Boards will have a formal scrutiny role or formal involvement with consultation on service change. Although as stated in the Health and Social Care bill “a local authority may arrange for a Health and Well-being Board established by it to exercise any other functions of the authority”.

4.7 HWBs have a crucial role in the formation of local out-of-hospital strategies ensuring that those strategies address the needs of the population as outlined in the Joint Strategic Needs Assessment (JSNA) and are consistent with the Joint Health and Wellbeing Strategy (JHWS). They have a particular responsibility for supporting the development of integrated service provision in their area such as through the development of section 75 arrangements.

4.8 In addition, we expect all Clinical Commissioning Groups to continue to engage with their relevant HWBs on the *Shaping a healthier future* programme and the development of the Out of Hospital commissioning strategies.

The current relationships in the healthcare and scrutiny landscape

5. Approach to engagement, scrutiny and decision-making

5.1 We wish to provide some clarity over both the legal and practical case for forming a NW London-wide JHOSC.

5.2 Current legislation (under the 2001 Health and Social Care Act, 2002 Regulations and 2003 Directions and Guidance) requires that "where a local NHS body consults more than one OSC on a proposal it has under consideration for a substantial development of the health service or a substantial variation in the provision of such a service, the local authorities of these OSCs shall appoint a JOSC for the purpose of the consultation. Once established, only that JOSC may:

- Make comments on the proposal consulted on to the local NHS body
- Require the local NHS body to provide information about the proposal
- Require an officer of the local NHS body to attend to answer questions in relation to the proposal."

5.3 The eight North West London boroughs are therefore required to set up a time limited JHOSC to consider and respond to the forthcoming proposals. Our hope is that this will have been set by March 2012.

5.4 The formation of a JHOSC is required in any service change programme that affects neighbouring boroughs, to enable a view to be taken across the whole patch affected. This is particularly relevant in the case of *Shaping a healthier future* where changes will affect almost 2 million people, with many services crossing borough boundaries. We believe that considering care across the whole area will enable us to plan services more effectively and more efficiently.

5.5 In line with legislation, several JHOSCs have been established across the country to focus on other reconfiguration programmes. In London these have included:

- A JOSC in South East London which considered proposals of the "A picture of Health" programme which looked at the reconfiguration of acute services; and
- A pan-London JHOSC which was established to review the consultation on changes to stroke and trauma services in London.

5.6 Only the joint HOSC may comment on proposals for service change where proposals impact on patients in the area of more than one local authority. It is therefore a key vehicle to enable Local Authorities to have appropriate input to any proposals for changes in NHS services in their area.

5.7 Additionally, in order to address concerns about the proposed level of engagement with the wider local authority landscape (including individual HOSC committees, other elected members, lead officers and Health and Wellbeing Boards) we would outline the following:

a. Where possible, programme representatives will be available (on request) to attend meetings of individual HOSC committees in order to provide programme updates and briefings and answer questions.

b. The Shaping a healthier future Out of Hospital (OOH) Working Group meets monthly to progress work on the vision for local out-of-hospital care. This group includes representatives from each local authority (members noted in Appendix 2).

c. Similarly, there are borough level OOH workshops taking place to discuss OOH vision & strategy for each borough. These generally include representatives from local authorities, such as Directors of Adult Social Services.

d. Our reconfiguration Clinical Board meets fortnightly and its membership is comprised of local clinical representatives, many of whom are also represented on local Health and Wellbeing Boards, such as the Clinical Commissioning Group Chairs.

e. All HOSC members will also receive regular updates from the *Shaping a healthier future* programme and are encouraged to contact the programme whenever more information is required.

5.8 As well as these regular opportunities for input and engagement, there will be additional opportunities provided by a number of key programme milestones.

a. This paper follows the first informal briefing session where HOSC chairs and officers were able to give their initial views on the programme and Case for Change. Another session will be held in the next month to review next steps and this will be another opportunity for input.

b. We are keen to work with HOSC Chairs on developing a forward plan for future engagement for the duration of the programme.

c. Involvement of local authorities in the engagement events noted in February and March.

Appendix 1

Summary of discussion and key points

1. A concern was raised that out of hospital (OOH) care should be enhanced before changes are made to hospital services. The response was given that some work was already in progress (STARRS and the Integrated Care Pilot for example) but that the programme is aware that there is much more to do.

2. A concern was raised that there is the potential for this emphasis on OOH care to lead to extra burdens on social care and therefore local authority budgets. The response was given that this is being considered; however, if patients are treated and supported in the right way, there should be less demand on social care. For example, the Integrated Care Pilot has resulted in a 10% drop in admissions to nursing homes.

3. A similar point was raised regarding the potential demand on OOH care given the geographic scale and demographic diversity of the region. It was reiterated that if the right care was given this should lead to decreased demand; however, this is an area that will be the focus of local discussions around the OOH vision for each borough.

4. It was also asked whether work on OOH strategies was part of the programme and it was confirmed that this does form a major strand of the programme and is also part of NHS NWL's ongoing work with local authorities.

5. A question was asked about the £1bn funding gap identified in the Commissioning Strategy Plan and whether the need to make cost savings should be more strongly reflected in the Case for Change. The response was given that this will be taken into consideration; however, the Case for Change and the Shaping a healthier future programme as a whole is based primarily around improving patient safety, clinical outcomes and patient experience. Affordability is simply one of the criteria against which any options for change will be tested.

6. A question was asked about the impact of the Ealing Hospital Trust / North West London Hospital Trust merger on the programme and vice versa. The response was given that the reconfiguration programme and the merger are separate (although related in their objectives) and that service change would have to happen even if merger was not in process.

7. A question was raised about the relationship between any JHOSC, the eight individual HOSC committees in NW London and the Health and Wellbeing Boards. This led to a discussion about how the three different groups would be engaged with and their respective roles when it comes to overview, scrutiny and decision-making.

8. A related concern was also raised that having a JHOSC would preclude further engagement between the programme and the wider local authority. However, assurances were given that this would not be the case but that there was both a legal and practical need for a pan-NW London body, not least because many of the services involved will cross borough boundaries and that this regional perspective will allow more effective and efficient planning of services. Additionally, there is a distinction to be made between decision-making, scrutiny and engagement.

9. A similar question was asked about the synergies between Health and Wellbeing Boards, public health teams and hospitals. The response was given that this is being considered as part of the out of hospital strategy work (together with the role of pharmacists).

10. It was raised that members would need to be well-informed about the programme and given the requisite supporting materials in order for them to be able to explain the programme and any potential changes to constituents. On this point, assurance was given that representatives from the programme would be eager to attend HOSC meetings in each borough to brief

members about the programme and Case for Change.

11. Similarly, members will need a better understanding of the parameters and content of the programme; specifically, what the JHOSC will be expected to consulted on and the key milestones and opportunities for input and engagement. The response was given that this will be considered and more information will be provided.

12. Three concerns were raised about the proposed public consultation period (proposed to start in June 2012 and to last 12 weeks). Firstly, that the impact of holidays and the London 2012 Games be taken into account, perhaps weighting activity during June and July rather than August. Secondly, that sufficient budget is allocated to consultation to ensure that it is robust and comprehensive. Assurance was given that both of these points would be taken into account and that the timetable is being driven by the need to address the challenges identified in the Case for Change and by Government guidelines.

13. Thirdly, that the consultation should be meaningful and that the public should feel engaged and that they have a genuine impact on the final decision. The response was given that at this point in the process there is no defined solution and clarity will be reached once the Case for Change and vision are developed.

14. A specific question was asked about the impact of purdah on the timing of the publication of options for service change. The answer was given that there will be early engagement on the options before purdah begins.

Appendix 2

Attendees on 16 January 2012

Local Authority representatives

	Name	Position	Borough
1.	Cllr Sandra Kabir	Chair	Brent
2.	Andrew Davies	Policy and Performance Officer	Brent
3.	Cllr Abdullah Gulaid	Chair	Ealing
4.	Cllr Anita Kapoor	Vice-Chair	Ealing
5.	Sue Perin	Committee Co-ordinator	Hammersmith & Fulham
6.	Cllr Vina Mithani	Vice chair	Harrow
7.	Fola Irikefe	Scrutiny Officer	Harrow
8.	Cllr Michael White	Chair (Health Services OSC)	Hillingdon
9.	Cllr Judith Cooper	Chair (Social Services OSC)	Hillingdon
10.	Nav Johal	Scrutiny Support Officer	Hillingdon
11.	Cllr Poonam Dhillon	Chair	Hounslow
12.	Deepa Patel	Scrutiny Officer	Hounslow
13.	Cllr Mary Weale	Chairman	Kensington & Chelsea
14.	Henry Bewley	Health Policy Officer	Kensington & Chelsea
15.	Louise Hall	Support Officer	Richmond
16.	Dr Mark Ewbank	Scrutiny Officer	Westminster

NHS NWL representatives

20.	Anne Rainsberry	Chief Executive	
21.	Dr Mark Spencer	Medical Director	
20.	Dr Tim Spicer	CCG Chair	
22.	Sarah Whiting	CE for Inner NWL	
23.	Daniel Elkeles	Director of Strategy	
21.	Lisa Anderton	Asst Director Service Reconfiguration	
22.	Jenna Goldberg	Communications Manager	
23.	Elizabeth Ricardo Binding	Communications Manager	

Members of OOH Working Group – Local Authority representatives

Brent	Phil Porter, Head of Service
Ealing	Stephen Day, Director of Adult Social Services
Harrow	Bernie Flaherty, Divisional Director of Adult Social Care
Hillingdon	Linda Sanders-Corporate Director/ Sarah Morris - Heads of Service
Kensington and Chelsea / Hammersmith & Fulham	Paul Rackham, Service Manager, Strategy and Commissioning and Market Development
Westminster	Andrew Webster, Tri-Borough Director of Adult Social Care

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North West London

Shaping a healthier future

NHS North West London

Case for Change

30 January 2012

Contents

OUR COMMITMENT

As clinical leaders in North West London, we believe that the case for making changes to how we deliver services in North West London is compelling and places a clear responsibility on us now to deliver better healthcare for our patients in years to come.

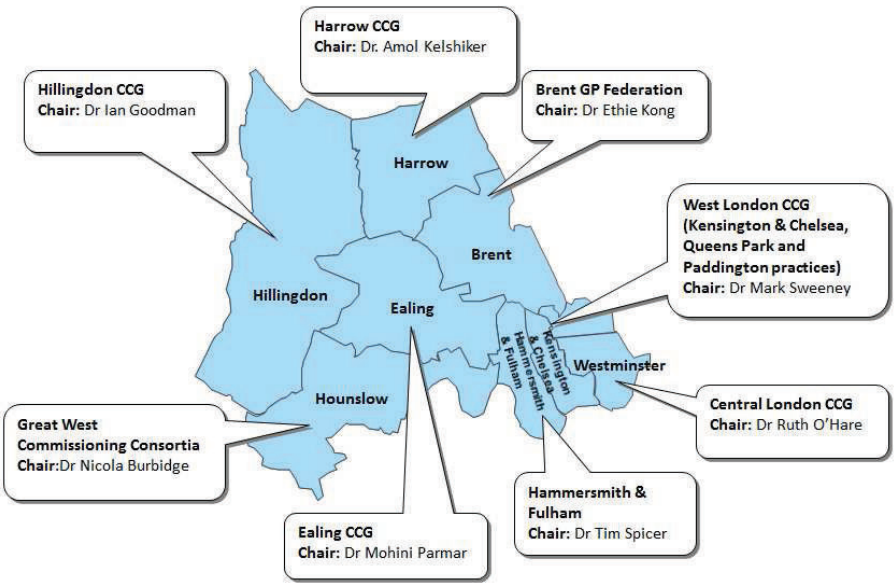
We believe that increasing the amount of care delivered closer to the patient's home will enable better co-ordination of that care, ensure the patient has access to the right help in the right setting and improve quality of care and value for money. We will take on that challenge. Its scale should not be underestimated, but neither should we underestimate the rewards of getting this right – better healthcare, more lives saved, more people supported and a system that is more efficient.

As the current and future commissioners of services in North West London and the leaders of the programme to deliver this change, we have made four key commitments. These underpin our vision for how services should work in the future and though there will be difficult decisions to make, these commitments are, we think, obvious, uncontroversial aspirations for any world-class healthcare organisation.

We would add one final pledge – to listen to our patients and staff throughout the process of change and make sure that we are always working to create a system that works, first and foremost, for them.

Dr Ethie Kong - Brent GP Federation CCG Chair
Dr Ruth O'Hare - Central London CCG Chair
Dr Mohini Parmar - Ealing CCG Chair
Dr Nicola Burbidge - Great West Commissioning Consortia Chair
Dr Tim Spicer - Hammersmith & Fulham CCG Chair
Dr Amol Kelshiker - Harrow CCG Chair
Dr Ian Goodman - Hillingdon CCG Chair
Dr Mark Sweeney - West London CCG Chair

The Clinical Commissioning Groups in NW London



Executive Summary

The health needs of the people of North West London are changing; demands on our health services are increasing; the way we have organised our hospitals and primary care in the past will not meet the needs of the future.

Therefore the way we deliver health care services must change.

The population of North West London ("NW London") is facing major changes in its health needs and these are placing ever greater demands on the local NHS. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia.

More needs to be done to improve care and prevent ill health, and improvements need to be made to ensure better, consistent access to high quality care.

For example, when people are worried about their health, their first point of call is often NHS primary care – usually their GP. But patients in some parts of NW London cannot get a GP appointment, or access their GP and related services, very easily. Patient surveys suggest six of the eight boroughs in NW London are in the bottom 10% nationally for patient satisfaction with out-of-hours GP services.

More should also be done to support the growing number of people in NW London who are elderly, or suffer from long term conditions. These patients need support to manage their condition, and help to stay as independent as possible.

Providing suitable care will mean providing more proactive services in the community and spending proportionately more on those services in local communities, and less on hospitals. Doing so could result in 20-30% of patients who are currently admitted to hospitals in NW London as emergencies being more effectively cared for in their community.

These challenges are not unique to NW London. We have made progress but there is more to be done. It is up to the NHS, in partnership with carers, the voluntary sector and social care to continue to focus on tackling these challenges.

Initiatives to provide enhanced levels of care outside hospitals such as the Short Term Assessment, Rehabilitation and Reablement Service ("STARRS") and the "Integrated Care Pilot", will prevent 2,000 people being admitted to NW London hospitals in 2012-2013. These schemes proactively plan the care for people to prevent them getting more seriously ill, combining primary, acute and mental health. If we rolled out these kinds of initiatives across the whole of NW London, up to 10,000 admissions to hospital could be avoided each year, leading to better care and more available resources. But more needs to be done by the NHS: primary care and hospitals need to change how they deliver care.

People needing hospital care must be sure of receiving the best possible services. This is not happening consistently across NW London. There are big differences in the quality of care patients receive depending on which hospital they visit and when they visit. Recent analysis across London has shown that people attending and admitted to hospital during evenings, nights or at the weekend are more likely to die than people admitted at times when more senior staff are available. Around 130 lives could be saved in NW London every year if mortality rates for admissions at the weekend were the same as during the week.

NW London also has more hospital floor space per head of population than in other parts of the country, and uses a greater proportion of the NHS budget on hospital care than average – but the productivity of NW London hospitals is lower than in other regions. This is not the best use of resources – resources which could be better used to help people to stay well in the community – and makes it even more important to change hospital services.

If the NHS is to provide more consistent high quality hospital care in NW London, it needs to ensure that senior doctors and teams are available more often, seven days a week, 24 hours a day.

Again, much progress has been made – for example, in centralising heart attack care, major arterial surgery and stroke care in hospitals. This has already saved about 100 lives over the last year in NW London – but more needs to be done.

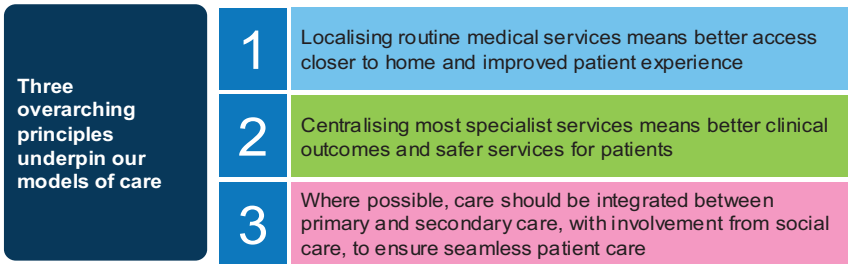
The physical condition of hospital buildings needs to improve. Despite having three relatively newly built hospitals (Central Middlesex, Chelsea and Westminster and West Middlesex), NHS buildings in NW London are generally in a poor state. Three quarters of hospitals require significant work to meet modern standards, at an estimated cost of £150m.

And all these challenges need to be met at a time of unprecedented economic pressure, which affects all of us, not just the NHS. Hospitals in NW London will have significant financial challenges even if they become as efficient as they can be.

The demand for health services in NW London will continue to grow and, given the economic pressure, the NHS needs to focus even harder on improving quality, safety, outcomes and experience, whilst also providing care in the most effective way.

In essence this means health services need to be localised where possible, centralised where necessary. This will mean we will need to review the current pattern of hospitals in NW London. In all settings, care should be integrated across health, social care and local authority wherever that improves seamless patient care.

The impact on providers of the Commissioning Strategy Plan



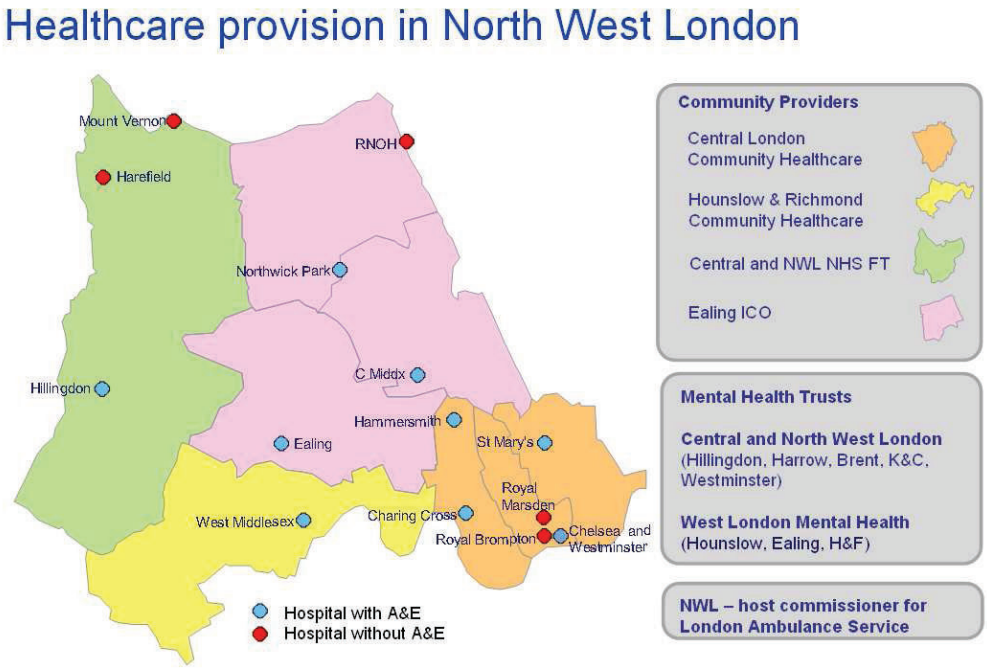
In short, the NHS in NW London needs to redesign services, so that

- You can be supported to take better care of yourself, lead a healthier lifestyle, understand where and when you can get treatment if you have a problem, understand different treatment options and better manage your own conditions with the support of healthcare professionals if you wish;
- When you have an urgent healthcare need, you can easily access a primary care clinician 24 hours a day, seven days a week by telephone, email and face-to-face consultations in local, easily accessible facilities;
- If you need to see a specialist or receive support from community or social care services, this will be organised in a timely way and GPs will be responsible for co-ordinating the delivery of your healthcare;
- If you need to be admitted to hospital, it will be to a properly maintained and up-to-date facility where you receive care delivered by highly trained specialists, available seven days a week, with the specific skills needed to treat you.

This document sets out how the NHS might achieve this change. We will be working with a number of NHS partners over the next few months to identify options to deliver our vision for change. There are plans to launch a major public consultation in June 2012. This will genuinely seek patient and public views and offer real choices about how their services can be better delivered.

1. Demands on the NHS in NW London are changing

The NHS in NW London includes eight London boroughs: Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster, each with its own clinical commissioning group[1]. NW London has a population of nearly two million people on which the NHS spends approximately £3.4 billion each year. There are nine acute and five specialist hospital sites and 423 GP practices. In addition, there are 505 pharmacies, two mental health and four community care providers delivering services from multiple sites, including people's homes[2].



This population is growing and life expectancy is improving. NW London is expected to increase by approximately 113,000 people (5.9%) growing from 1.9 million to 2.0 million in the next 10 years. This represents a significant pressure on the NHS.

Thanks to earlier diagnosis and improved treatments, fewer people are dying prematurely from diseases such as cancer, heart disease and strokes. Since 2001, the number of people under 65 dying from cancer has dropped by 15%, the number dying from heart disease has dropped by 38%, and the number dying from stroke has dropped by 36%[3].

These improvements mean people are living longer and, as a result, the population as a whole is getting older. Ten years ago life expectancy in NW London was 76.8 years for men and 81.9 years for women but it is now about three years longer – 80 years for men and 84.5 years for women[4,5].

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[1] CCGs are closely to aligned to the boundaries of local authorities

[2] NHS Choices

[3] NHS Information Centre

[4] GP registered population figures used to calculate population weighting of each NW London PCT. Life expectancies associated with each NW London PCT then multiplied by weighting to produce 'average' life expectancy for NW London

[5] NHS Information Centre

For the NHS, this is hugely significant because older people are more likely to develop long term conditions such as diabetes, heart disease and breathing difficulties and are more at risk of strokes, cancer and other health problems. Three out of every five people aged over 60 in England suffer from these kinds of conditions and, as the population ages, there will be more people with age-related diseases.

Some 300,000 – nearly 1 in 6 – of people all ages in NW London, have one of the following five conditions: diabetes, asthma, coronary heart disease (CHD), chronic obstructive pulmonary disease (COPD), and cystic fibrosis disease (CFD)[6].

Adding to these pressures, modern lifestyles are creating problems. In particular, unhealthy eating and lack of exercise is resulting in increasing rates of obesity and diabetes. In Westminster, 29% of 10 to 11-year-olds are obese compared to only 12% in Richmond[7]. Diabetes prevalence in NW London rose from 3.6% to 5.7% between 2004/5 and 2010/11[8]; obesity prevalence (in adults) in London rose from 18.2% to 23.2% between 1998 and 2008[9].

It is estimated that roughly one in five people smoke[10] and the number is higher in more deprived areas. Smoking (and other forms of tobacco consumption) are the UK's single greatest cause of preventable illness and early death. A recently published paper estimated that around 107,000 people died in 2007 from smoking-related diseases[11]. In addition, alcohol abuse is leading to increasing rates of liver disease and other associated conditions.

Fortunately our ability to prevent, diagnose and treat medical conditions is constantly improving. New treatments emerge as the boundaries of medical science and technology change. These offer new ways of tackling old problems leading to increased rates of survival from life-threatening illnesses.

For example, heart attacks used to kill 73,000 people a year in 1993 but now only kill 25,000 annually[12]. In just eight years between 2002 with 2010, mortality rates fell by 50% in men and by 53% in women[13]. This is due to a combination of factors, for example fewer people smoking, and the introduction of procedures such as percutaneous coronary intervention (PCI) – where a fine tube is inserted through a blood vessel and a tiny balloon is inflated to unblock arteries in the heart.

However, only a few of our hospitals can provide this as the delivery of PCI as an emergency treatment for heart attacks requires that specialists are available 24/7. Instead of going to any hospital, patients needing PCI are directed to hospitals such as Hammersmith or Harefield. With 86% of patients receiving PCI within 150 minutes of calling for help, this technology is measurably saving lives[14].

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6 QOF, Proportion of the GP registered population in NW London who are on the CHD, COPD, CFD, diabetes and asthma registers

7 Prevalence of Childhood Obesity by Borough, 2006-2010, Greater London Authority

8 QOF prevalence tables

9 NCHOD

10 Based estimates of current smoking, 2003–2005 by SWL PCT (Source: Household Survey for England (HSfE) 2006

11 Peto, R et al, Mortality from smoking in developed countries 1995,2007 (2010

12 Mortality from Acute Myocardial Infarction in England: 1993 – 73,824, 2009 – 25,264, NCHOD

13 Determinants of the decline in mortality from acute myocardial infarction in England between 2002 and 2010: linked national database study, BMJ 2012;344:d8059 doi: 10.1136/bmj.d8059 (Published 25 January 2012)

14 MINAP Public Report, 2010

This kind of advanced medical treatment depends on better technology and equipment, operated by more specialised clinicians. The general surgeon of 20 years ago effectively now no longer exists. Instead, surgeons now specialise in different conditions and different parts of the body. There are currently 24 professional associations and expert groups that represent the interests and set standards for the varying surgical specialties, techniques and patient groups[15]. Until recently cardiology did not even exist as a specialty – now it is a major clinical specialty with a number of sub-specialties.

This in turn means the traditional ways of organising care in the NHS have had to change. A recent report by The King's Fund[16] has underlined how advances in medicine and surgery have led clinical staff and equipment to become more specialised, leading to specialist teams brought together into fewer, larger hospital sites so that skills can be maximised and patient outcomes improved.

Medical advances also mean fewer hospital beds are needed. Most routine surgery is now done in just one day ("day surgery") and 80% of all patients have stays in hospital of fewer than three days[17]. Not surprisingly therefore, the number of hospital beds in NW London has fallen by about 9% over the last five years[18].

As medicine and surgery continue to become more specialised, and new techniques allow people to go home even earlier, or avoid going to hospital at all, the number of hospital beds will reduce even more.

The rise of the internet, mobile communications, and 'telehealth'[19] all provide other new ways for patients to access advice about their health and communicate with health and social care professionals. This creates more opportunities to support patients in their own homes and receive services, traditionally based in a hospital, through more local facilities such as GP surgeries. So services will be moved closer to patients' own homes.

Although the Government's pledge to protect health budgets meant they fared well compared to some other areas of public spending, analysis suggests expenditure will only be increasingly very slightly in real terms in the years up to 2015[20].

Against this, the financial pressures caused by the increasing age of the population, the increased burden of more ill health and the need to keep pace with new technology would need growth of 5%[21] each year unless we change the way services are delivered. As a result, the 2010 Spending Review committed the NHS to finding £20bn in productivity improvements by 2015 to reinvest in services to meet increasing demand.

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15 http://www.rcseng.ac.uk/media/spec_assocs.html

16 Reconfiguring Hospital Services, 2011

17 Hospital Episode Statistics

18 Department of Health

19 Using technology such as the internet to remotely monitor and care for people's conditions

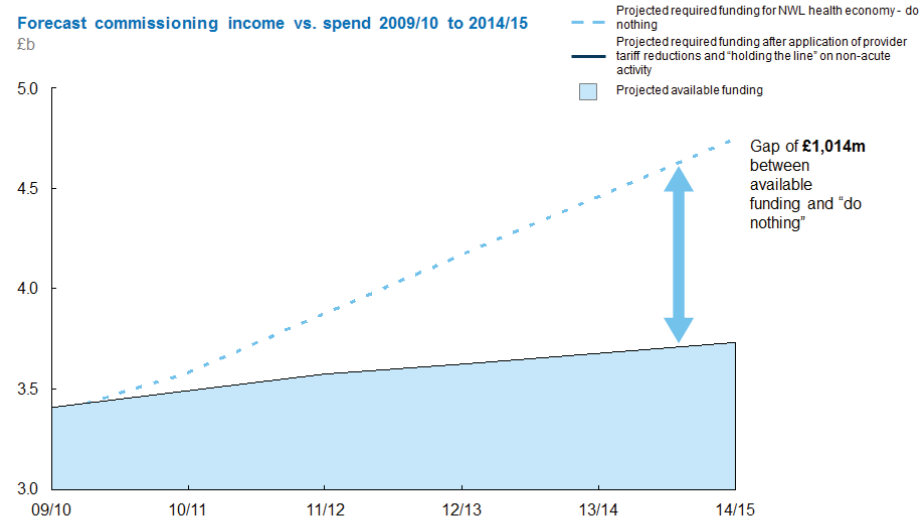
20 Where next for the NHS reforms? The case for integrated care, The King's Fund, 2011

21 NHS NW London modelling

This means the NHS is required to deliver efficiency savings of at least 4% a year – something which has never been delivered before[22]. The total spend in the NW London health economy is £3.4 billion, which represents 24% of all NHS expenditure across London. Based on current services, by 2015 we estimate we could need an additional £1 billion of funding over and above that which is likely to be available, in order to keep pace with all these demands. This means services need to be redesigned to be more affordable.

The diagram below shows the scale of the financial gap if we do not take action in NW London.

Under the alternative scenario, North West London needs to close a projected £1bn funding gap



SOURCE: HfL, NHSL planning guidance, local planning assumptions

[22] Where next for the NHS reforms? The case for integrated care, The King's Fund, 2011

2. The NHS in NW London has also been changing

As the demands on the NHS have changed and available resources have become ever more limited, the NHS itself has been changing. This means more than simply improving individual services, it means better integrated working within the NHS and better partnership working with councils, schools, and the voluntary sector.

The doctors, nurses, other clinicians, managers and staff of the NHS in NW London have been working hard to constantly improve healthcare delivery across hospital, primary care and in local communities. This has helped to ensure that critical services have started to be centralised where necessary to deliver high quality care.

At the same time the NHS has improved the way services are delivered in the community so care is delivered as close to where patients live as possible, and is integrated with local hospitals.

Below are a number of examples of where the NHS has been able to localise, centralise and integrate services to provide better care.

Examples of centralising specialist services in NW London:

Major Trauma:

People who suffer a serious injury or major trauma need high quality, specialist care to give them the best chances of survival and recovery. From 2010, NW London patients have received new world-class trauma care through the London trauma system. This is made up of four trauma networks. Each has a major trauma centre, including one at St Mary's Hospital in Paddington, for treating the most seriously injured patients, linked in with a number of local trauma units for treating those people with less serious injury. During the first year the system has saved the lives of an estimated 58 people in London who would otherwise have been expected to die[23]. The network has prevented disability for many more.

Stroke Services:

The provision of stroke services across London, including NW London, has dramatically improved. This new approach is thought to have prevented an estimated 300 deaths per year in NW London[24].

Only three years ago, stroke care was fragmented across the capital, being delivered in all of the 31 acute hospitals. Now a dedicated network of eight "hyper-acute" stroke units operate across London – in NW London at Northwick Park and Charing Cross Hospitals – to improve treatment for patients.

Each is staffed by stroke experts day and night to assess, diagnose and treat stroke patients within 30 minutes of arrival and to provide immediate care for the first 72 hours or until the patient has stabilised. Good care requires that we provide immediate access to a brain scan and clot-busting drugs, where appropriate, and thus these units are open 24/7. These eight units are supported by 24 stroke units across London to provide ongoing care once a patient is stabilised, including multi-therapy rehabilitation.

Now, four times as many patients are treated with clot-busting drugs, reducing disability, there is less variation in death rates around the capital and patients spend less time in hospital. The average journey time in London for a patient being taken to the new units is 14 minutes.

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[23] London Trauma Office

[24] NHS press article: "Specialist stroke centres save lives across the capital"

Examples of improved local care in NW London:

STARRS

The STARRS scheme (Short Term Assessment, Rehabilitation and Reablement Service) in Brent has improved the transition for patients between acute hospital services and community services, reducing the need for patients to go to hospital and leading to a much better, more independent quality of life. STARRS is an innovative new approach to provide rapid response, discharge support and rehabilitation, and access to community health beds. It includes a multi-disciplinary team of nurses, physiotherapists, occupational therapists, doctors, dieticians and healthcare support, as well as an administrative team who act as a single point of access for GPs and hospital staff so they can refer patients directly to the service.

Integrated Care Pilot

A major frustration of patients with long term conditions is that their care is not effectively coordinated across the boundaries of multiple different NHS organisations. As a consequence they often have to repeat information multiple times and deal with many different clinicians. To address this, an Integrated Care Pilot ("ICP") has been set up focusing on the care of people aged over 75 or with diabetes. The ICP overcomes the boundaries between hospitals, community care services, social care and local authorities to allow faster access, streamlined for patients and a stronger focus on their long term needs. Through integrated care, providers work together as a team so that patients receive the right kind of treatment, in the right place at the right time. In addition patients are provided with more control over the care that they receive.

The pilot has already won a national award and is being seen as a model for how primary and community services can work better together to safely support people at home, reduce unnecessary hospital visits and provide a more seamless patient experience. The clinical teams within the ICP - with a complementary mixture of skills - have held over 50 integrated case conferences discussing over 400 patients. The GP practices involved have initially experienced a 3.8% reduction in non-elective admissions for diabetic and elderly patient groups, compared to just less than 1% for non-involved GP practices. This reduction is likely to increase as the pilot becomes fully operational[25].

There is also ongoing work to improve local care:

Commissioning for quality

NHS NW London is underpinning its work on quality through the production of a series of quality standards. To bring these quality standards to life, we have with the input from our Clinical Commissioning Groups, described a series of patient stories that set out the ideal care that patients should receive when they use the NHS. The patient stories, although fictitious, cover all settings of care and the main types of illnesses that people experience. Underpinning each patient story are published standards, metric and guidelines from, for example, the Royal Colleges and National Institute for Clinical Excellent (NICE). The standards have been prioritised and we have chosen several to use in commissioning services for 2012/13. The full suite of stories and standards can be found on the NHS NW London website[26].

[25] North West London Integrated Care Pilot interim evaluation, 4th January 2012

[26] www.northwestlondon.nhs.uk

Teaching and Research

NW London is a major international centre for teaching and research. At the heart of this sits our Academic Health Science Centre (AHSC). AHSCs are a new approach to healthcare in the UK, bringing a university and the NHS together and running them hand-in-hand to provide the best healthcare in the world. AHSCs help increase the speed at which new treatments can be moved from the laboratory bench to the patient's bedside, providing faster access for patients to the latest, innovative treatments.

Imperial College Healthcare NHS Trust and Imperial College London came together in October 2007 to create the UK's first AHSC. Working together with its healthcare partners, the AHSC has and will continue to bring significant benefits for patients, staff, students and North West London's local population. It will also have wider benefits as the AHSC takes new discoveries and promotes their application in the NHS and across the world. It is top of the table for recruiting patients to clinical research studies, recruiting 69,260 patients in 2010/11 - more than any other NHS Trust in England.

The AHSC builds on North West London's position as one of the world's foremost clusters for biomedical research and teaching. This enables us to provide patients with access to the latest clinical developments. The Academic Health Science Centre, is at the forefront of technology and research programmes. It has received £112m of funding for its Biomedical Research Centre (the largest amount given to any partnership). NW London research to help people living with complex heart and lung conditions was recently recognised with a grant of almost £20 million to two Biomedical Research Units (BRUs) run jointly by Royal Brompton & Harefield NHS Foundation Trust and Imperial College London.

ASHCs support the position of NW London as a hub of medical education. There are over 4,000[27] medical trainees in North London at any time enabling us to attract some of the best experienced doctors to highly prestigious teaching posts. The NHS in North West London is working hard to ensure that we maintain our position as world leading centre of teaching and research and to ensure that position translates into real benefits for patients.

27 POINT OF VIEW SURVEY 04-05, London Deanery

3. But more change is still needed…

3.1 … to prevent ill health in the first place

For the NHS, it is critical that now and in the future, people who live in NW London receive the highest quality of healthcare and are able to live healthy lives no matter where they live, how much money they have, or what their background is.

But, like most areas of London, the North West of the capital is highly diverse, with very wealthy people living side-by-side with very poor households. And health varies just as much as wealth. In fact there is a strong link between poverty and health: evidence has demonstrated that the poorer you are, the more you are likely to suffer ill health.

The result is that there is currently a difference of up to 17 years in life expectancy between different wards in NW London. For men, Queen's Gate (in Kensington & Chelsea) has the highest life expectancy (88.3 years) and Harlesden (Brent) has the lowest (71.5 years). For women, Knightsbridge and Belgravia (Westminster) has the highest life expectancy (90.3 years) and Church Street (Westminster) and Feltham North (Hounslow) have the lowest (both 76.6 years)[28].

This can be caused by many things, including differences in living conditions, diet, levels of smoking and drinking, access to sport and leisure activities, social and support networks, as well as barriers to healthcare, including seemingly obvious things like language and literacy. A recent Strategic Review of Health Inequalities in England has highlighted the link between education, employment, and health[29].

Some ethnic groups tend to have poorer health outcomes than others. Work by the London Health Observatory suggests that Bangladeshi, Black African and Black Caribbean ethnic groups have significantly higher mortality rates than the overall population of the capital[30].

Some evidence suggests that Pakistani men are significantly more likely to suffer coronary heart disease or stroke than the general population. Poorer health among London's black and minority ethnic groups can partly be explained by other associated factors, such as lower employment rates[31].

Smoking, and other forms of tobacco consumption, are the UK's single greatest cause of preventable illness and early death, with around 107,000 people dying in 2007 from smoking-related diseases[32].

Clearly, more needs to be done to tackle these inequalities. Much can be done through successful promotion of public health information and campaigns that assist people to take personal responsibility for their own health. For example, the NHS and local councils can encourage people to give up smoking and avoid alcohol abuse.

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28 Greater London Authority (London.gov.uk)

29 Fair Society Healthy Lives, Marmot Review, Executive Summary, Review of Health Inequalities in England, Post 2010

30 London Health Observatory, Ethnicity and mortality in London Rhiannon Walters, Justine Fitzpatrick and Ed Klodawski, March 2009

31 All statements in this paragraph based on data from Review of Evidence for the Mayor's Health Inequalities Strategy, August 2009, GLA.

32 Peto, R et al, Mortality from smoking in developed countries 1950-2005,2007 (2010)

So more needs to be done to promote health and stop the people of NW London getting ill. More proactive primary care and better integrated working needs to happen so that the whole system – from schools, to GPs, from community nurses to hospital doctors – works seamlessly to support everyone to lead healthier lives.

3.2 … to provide easy access to high quality GPs and their teams

People want to be able to see a doctor or a nurse in their GP practice easily, and quickly, whenever they have a health problem. Equally, when they have less urgent problems they want to be able to see their GP without having to take time off work. When they do see their GP, people want to feel that they are being treated with care and concern. Failing to provide such basic level of access to GP care simply results in more people resorting to using A&E services.

A&E services are not only more costly to deliver but also 'episodic' – they lack the continuity and historic knowledge that a GP practice can provide, resulting in poorer care for the patient. Despite many GP practices offering a good quality service, many patients still find it too hard to access good quality care.

Patient satisfaction with primary care is low in all eight NW London boroughs when compared with national levels:

- On average, 1 in 4 patients in each NW London GP practice are dissatisfied with access, and feel unable to see their doctor fairly quickly within the next 2 working days. The majority (79%) of GP practices in NW London have below national average satisfaction scores[33]. This could, in part, lead to the higher than average use of A&E in outer NW London in particular[34].
- Similarly, 1 in 4 patients in NW London do not feel that they are being treated by their GP with care and concern.
- In terms of communication and access (such as communications by the doctor, level of empathy, satisfaction with out-of-hours service), five of the NW London boroughs rank in the bottom 10% of all parts of the country[35].

The effectiveness with which services are being delivered by GP practices is also highly variable and often below national averages. The rate of A&E use is high across outer NW London (Brent, Ealing, Harrow, Hillingdon and Hounslow). In particular, emergency admissions are much higher in Ealing and Hounslow (595 and 495 per 100,000 population vs. a national average of 410 per 100,000)[36,37]

GPs should track the blood pressure of all patients identified with high blood pressure. Some practices in NW London track all patients with high blood pressure every nine months, whereas others they are only managing this for two out of every three of these patients. This kind of variation means we are not consistently delivering the kind of high quality primary care we should be.

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[33] GP Patient Survey, 2010/11

[34] GP Patient Survey, 2010/11

[35] GP Patient Survey, 2010/11

[36] Emergency hospital admissions: acute conditions usually managed in primary care (ICD-10 codes H66.0 - H66.4, H66.9, I11.-, I50.0, I50.1, I50.9, J02.0, J02.8, J02.9, J03.0, J03.8, J03.9, J04.0, J06.0, J06.8, J06.9, J31.0 - J31.2, N15.9, N39.0, N30.0)

[37] DH A&E Activity Statistics 2008/09, Quality and Outcomes Framework (QOF) 2008-09

3.3 … to support patients with long term conditions

In the future, many more people will be living with long term medical conditions. By this we mean health problems that are present for over a year or more, such as diabetes, heart disease, respiratory problems and asthma.

Across the UK, patients with long term medical conditions make up 31% of the population but account for 52% of GP appointments and 65% of planned hospital appointments.

These patients need very good, consistent and integrated hospital, primary and social care and when this is not delivered the impact on the lives of individual patients can be devastating. Shuttled constantly in and out of hospital, some are simply unable to lead normal lives.

Quotes from the Health Care Commission and Diabetes UK on patients' experience of inpatient care make particularly disturbing reading:

> *"Because I have Type 2 diabetes, I was informed that I would need to be admitted the night before so that my diabetes could be monitored by specialist staff. During my stay I saw no-one from the diabetes care team."*

> *"If the NHS wishes to save money, it perhaps should first look at diabetics who do not want to stay in hospital for yet another night, but who are unable to get out because their insulin is impounded, with nobody with sufficient authority to return diabetic control to the patient."*

> *"…keep your wits about you as the ignorance of diabetes by a lot of staff is verging on criminal."*

Patients should be empowered and encouraged to help themselves so they don't have to see a doctor and have more control over their lives. There are tools available to support this, such as NHS Direct.

In NW London there are big differences in how well people with long term conditions are cared for, and big differences in their health as a result.

One of the complications of diabetes is reduced blood flow to the legs which, if not identified and treated at an early stage, can result in amputation. Patients who are cared for at practices with specialist clinics, supported by a diabetic nurse, are much less likely to need an amputation compared to those people looked after at practices without these specialist services[38].

Unfortunately, there are not enough of these specialist services in NW London and as a result, amputation rates in some GP practice catchment areas are much higher than elsewhere[39].

People with long term conditions also create a heavy burden for our hospitals – based on a Department of Health methodology, NW London estimates people living with such conditions currently account for 67% of all hospital bed days[40].

The NHS has come up with solutions to these problems, including the NW London Integrated Care Pilot already described above. In Ipswich, a pilot project which has helped 107 patients to better manage their own conditions has seen a 75% reduction in GP visits and a 75% reduction in bed days in hospital over a six-month period. Staff are being trained to become 'health coaches' to their patients.

Sutton Council has installed monitoring devices in patients' homes so GPs can monitor their clients' blood pressure, blood oxygenation and other indicators so they can take early action. A six-month pilot in the borough reduced admissions to hospital and saved around £322,000[41].

3.4 … to enable older people to live more independently

People who are older can struggle, like those with long term conditions, to live independent lives. Most elderly people want to be able to live in their own homes, and not spend time in hospitals. They need support to do this from social care, the NHS and the local community working together in an effective way. When this works well it can prevent problems, for example patients who fall, and keep people healthier for longer by keeping them out of hospital.

This is backed up by clinical findings. In hospital, older people are at risk of developing further conditions such as delirium, malnutrition, pressure ulcers, venous thromboembolism, hospital acquired infection, incontinence, functional decline, depression, falls and dehydration.

38 Matching the numerator with an appropriate denominator to demonstrate low amputation incidence associated with a London hospital multidisciplinary diabetic foot clinic, J Valabhji, et al, Diabetic Medicine, 2010

39 Total lower limb amputation rates per 1,000 adults with diabetes vary in NW London, Yorkshire & Humber Public Health Observatory.

40 http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_128890

41 http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_125211

A recent report made this point very clearly:

> *Hospitals are a dangerous place for older people. Around one in ten patients in UK hospitals, the majority of whom are elderly, experience an adverse event during their hospital stay ….Adverse events are traditionally defined as unintended injuries caused by medical management rather than the disease process, which are sufficiently serious to lead to prolonged hospitalisation, or temporary or permanent disability, or death…. Older patients are more susceptible to adverse events than their younger counterparts as they are more complex, with multiple co-morbidities, increased dependence and reduced physiological reserve [42]."*

An analysis by Chelsea and Westminster showed that 30% of readmitted patients were over 70 years old[43]. Similarly, an analysis at Imperial College Healthcare Trust showed that 40% of readmitted patients were 65-84 years old[44].

It is incumbent on the NHS in NW London to help prevent elderly patients going to hospital in the first place, by improving the management of their conditions and when basic treatment is needed and when it is appropriate, moving care out of hospital altogether. Currently too many older people end up in hospital when, with appropriate out of hospital care, they could be treated in the community and looked after in their own home.

Equally, at the end of people's lives, more want to die at home rather than in hospital, and the NHS needs to do more to enable this. In NW London, only 18% of people are dying at home versus a national average of 23%[45] and in contrast to the wishes of 54% of patients to die at home[46].

For those approaching end of life, there are proven ways to improve the end of life experience of patients and their families, for example following documented best practice such as the Liverpool Care Pathway[47]. We need to do more to implement these.

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[42] Identifying Risks to Older Patients – A Scoping Exercise - A Report for the Dunhill Medical Trust April 2009

[43] Emergency Readmissions at Chelsea and Westminster Hospital

[44] Readmissions Action Plan Imperial College Healthcare Trust

[45] National Centre for Health Outcomes Development - Compendium indicators 2010-2011

[46] http://www.londonhp.nhs.uk/services/end-of-life/case-for-change/

[47] The Liverpool Care Pathway helps doctors and nurses plan for what patients can expect in the final days and hours of life, which also becomes a structured record of the actions and decisions that develop.

4. Hospitals in particular need to change …

While the NHS will continue to focus on keeping people healthy and treating them, where possible, in the community or their own homes, there will always be the need to treat some patients in hospitals.

In NW London, however, the NHS is struggling to deliver consistent, high quality hospital care:

- Patient experience is generally poor across NW London hospitals
- Many staff would not be comfortable sending their own relatives to hospitals in NW London
- There is marked variation in the quality of acute hospital services in NW London

4.1 … to improve patient and staff satisfaction

Patients are now regularly surveyed on their experience of hospital services and, in NW London, these results are mixed.

Only the three specialist hospital trusts in NW London have scores substantially higher than the national average when it comes to overall patient experience[48]. Across the other five measures collected by the Care Quality Commission (CQC) non-specialist hospitals score about the same or lower than the national average.

Staff are also regularly surveyed and, worryingly, in some NW London hospitals, a significant number of staff do not 'agree' or 'agree strongly' that they would recommend their hospital as a place to work or to be treated[49].

This means that not just patients, but also those closest to delivering frontline care themselves do not believe services delivered in NW London hospitals are up to standard.

4.2 … to make high quality more consistent

There are thousands of emergency admissions to NW London's hospitals each year. Typically, these patients do not have the choice of where they are treated. They are also among the sickest patients that are cared for in hospital.

The NHS believes these people should all receive consistently high quality services any day of the week, at any time.

[48] CQC patient satisfaction survey 2010

[49] National NHS Staff Survey 2010

In general, the clinical quality of hospitals in NW London compares well to the national average in terms of mortality rates. But there remain significant variations in mortality – for example, standardised mortality rates at Imperial are significantly lower than the other hospitals in NW London[50]. *Fuller comparisons of hospital mortality are provided in the appendix.*

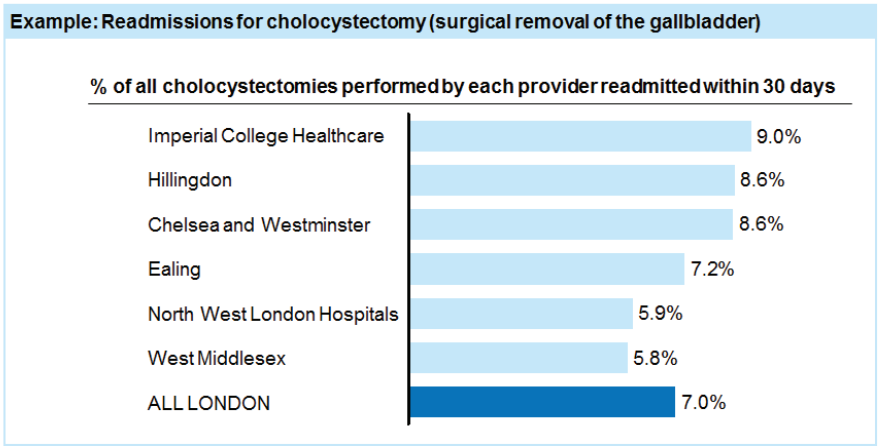
A pan-London study in 2011 established that there is a greater than 10% higher mortality rate in London for emergency admissions at the weekend, compared to weekdays, due to a lack of consultant cover and access to diagnostics at weekends[51]. Data for London shows that patients admitted at the weekend are more likely to die from an emergency admission compared to a weekday – around 130 lives could be saved across NW London every year if mortality rates for admissions at the weekend were the same as during the week in NW London trusts[52].

In other areas of care, there are far greater variations in quality – for example, when looking at readmissions to hospital after a number of procedures, the proportion of patients who need to be readmitted varies considerably from one hospital to another.

For example, readmissions for cholecystectomy (the surgical removal of the gallbladder) vary substantially. This can be due to multiple reasons, but one reason is differences in the way in which patients are cared for which results in complications after surgery.

Readmission rates for some basic surgical procedures are high in some NWL hospitals

Based on readmissions April-Sept 2011



50 AES-Case-for-change-September-2011; Dr. Foster Ltd

51 Aylin, Yunus, Bottle, Majeed, Bell: Weekend mortality for emergency admissions. A large, multicentre study, NHS London: London Health Programmes Adult emergency services – Case for change (2011)

52 High Quality Hospital Provision in London – an Analysis: Quotes 520 lives could be saved across London, North West London estimated to account for 25% of these

4.3 … by providing 24/7 access to specialist emergency care

Clinical evidence compiled over a number of years now[53] has highlighted that, in relation to emergency care services, early involvement of senior medical personnel in the assessment and subsequent management of many acutely ill patients improves outcomes i.e. patients suffer fewer complications and are less likely to die when they are cared for by senior, more experienced staff.

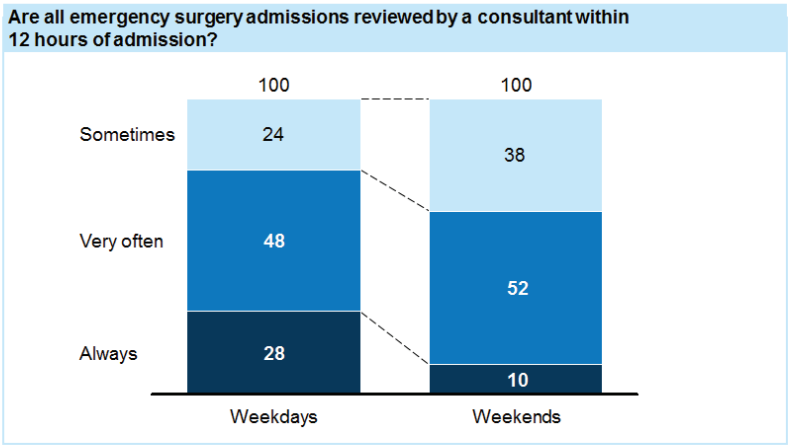
A self-reported survey of London trusts, undertaken in March 2011, demonstrated there is considerable variation in the availability of senior experienced staff to care for patients between hospitals and between the service provided on weekdays compared to that at weekends. Findings included:

- Senior doctor availability in acute medicine and emergency general surgery at the weekends is more than halved at many sites compared to cover during the week;
- Patients admitted on a Saturday have a 16% greater chance of dying than if admitted on a weekday, with a corresponding figure of 11% on a Sunday.
- This is a group that has the least access to senior clinicians and diagnostics when they most need it.

The diagram below shows the significant reduction in review of emergency surgery admissions by senior doctors at weekends compared to weekdays.

Less than half of emergency general surgical admissions are reviewed by a consultant within 12 hours

Percent



- **Best practice recommendations state that emergency admissions should see a consultant within 12 hours**
- **In North West London, four hospitals are not always meeting this best practice**

Source: Survey of London acute trusts (2011)

[53] National Confidential Enquiry into Patient Outcome and Death. (2007). Emergency admissions: A step in the right direction, *NCEPOD,* Royal College of Surgeons (2011) Emergency Surgery: standards for unscheduled surgical care. Guidance for providers, commissioners and service planners. *The Royal College of Surgeons of England,* Royal College of Physicians. (2007). Acute Medical Care: The right person, in the right setting – first time. Report of the acute medicine task force. *Royal College of Physicians*

This is not just a London challenge – the College of Emergency Medicine has said that consultant cover in emergency departments is inadequate nationally. The benefits of increased consultant presence includes improving care (how well patients recover, how quickly patients are seen) and how efficient the unit is.

The College is actively targeting this issue and is now aiming to provide 10 whole time equivalent consultants as a minimum in every emergency department, nationally. But only one trust in NW London is currently providing this level of cover.

This lack of staff means that patients are not being quickly seen by a consultant when they arrive in hospital. A survey in 2011[54] showed that in four NW London hospitals, emergency general surgery admissions were not always reviewed by a consultant within 12 hours (Chelsea and Westminster, Northwick Park, St. Mary's and West Middlesex University Hospitals).

The survey also found that four hospitals (Central Middlesex, Ealing, St. Mary's and West Middlesex University Hospitals) did not free their consultants from other duties when providing emergency cover.

Just as for emergency care, in maternity services the Royal College of Obstetricians and Gynaecologists (RCOG) has recommended that there should be a substantial increase in the presence of senior obstetricians in NHS hospitals.

Babies can be born at any time of the day or night, any day of the week, and complications can occur at any time. Women and their families rightly expect there to be senior staff available to deal with any problems which may occur.

Consequently, it is recommended that the largest maternity units (between 4,000 and 8,000 births per year) should provide round the clock senior doctor presence; while other units should provide 98 hours of cover a week[55]. Senior doctor presence in NW London is significantly below these levels, with current averages of between 48 and 66 hours of senior doctor presence in local maternity units per week.

Implementing Royal College recommendations for obstetric presence on a labour ward is challenging not just within London, but nationally. In addition, there are shortages of midwives and neonatal nurses which leads to poorer quality care for women and babies.

This is not a problem that can be solved by simply training and hiring more doctors, nurses and other clinicians. To provide safe and effective care, clinicians need experience of dealing with complications on a regular basis. They cannot get this experience if they are spread across lots of hospitals.

Moving to higher rates of senior staff at all times of the week will mean reducing the number of units providing emergency care.

At the same time, the introduction of the European Working Time Directive (EWTD) has quite rightly restricted the number of hours junior doctors can work to prevent them being over tired.

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[54] Survey of London Acute Trusts 2011

[55] The Future Workforce in Obstetrics and Gynaecology (RCOG 2009)

Traditionally the NHS has relied on junior doctors to provide a lot of frontline medical care, particularly at evenings and weekends, so this is posing a real challenge. It is now much harder for smaller units to ensure that medical cover is available at all times of the day and night[56].

Since the application of the EWTD to junior doctors, there has been a 50% increase in the number of junior medical staff required to provide 24/7 care and many units have struggled to achieve this[57]. An example of where these challenges have been faced is Central Middlesex Hospital.

Central Middlesex Hospital A&E

Providing good hospital care, to a consistently high standard, across NW London, is not just about the quality of care delivered – it is also about the quality and availability of those delivering the care.

The A&E department at Central Middlesex Hospital has temporarily reduced the hours it is open because it does not have sufficient clinical staff, of the right level and expertise, available all the time. Departments such as this are finding staff recruitment challenging as the labour market is constrained and the roles are less attractive than those at larger centres.

There are also national shortages of some clinical staff groups, such as paediatricians, midwives, radiologists and pathologists (these latter two are important because of the work they do to support A&E, surgery and other services). National shortages due to the numbers of individuals currently entering training are expected to continue in the future. Though this is not simply a question of training and hiring more staff as even if there were more suitably trained staff in place, they would quickly begin to lose their skills as they would not be seeing sufficient volumes of patients.

These problems are not new; indeed they have been there for a long time. But as we have continued to improve our care provision, these areas have become increasingly noticeable and it has been demonstrated how care improves when we have the right supervising specialist staff available 24/7.

4.4 …and by providing access to specialised care

In some areas, quality of care is related to specialist teams who gain skills because of the increased numbers they treat. It has long been established from many clinical studies and reports that the more specialised doctors and other professional staff become, the better the results for patients.[58]

For example, specialist surgeons achieve better results for their patients than generalist surgeons performing the same operation in 9 out of 10 cases. Patients treated by a specialist surgeon are at lower risk of death, are likely to have fewer complications and are likely to benefit from shorter stays in hospital[59]. Specialists become proficient by dealing with large numbers of similar cases.

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56 The King's Fund Briefing 2011, Reconfiguring Hospital Services

57 The King's Fund Briefing 2011, Reconfiguring Hospital Service

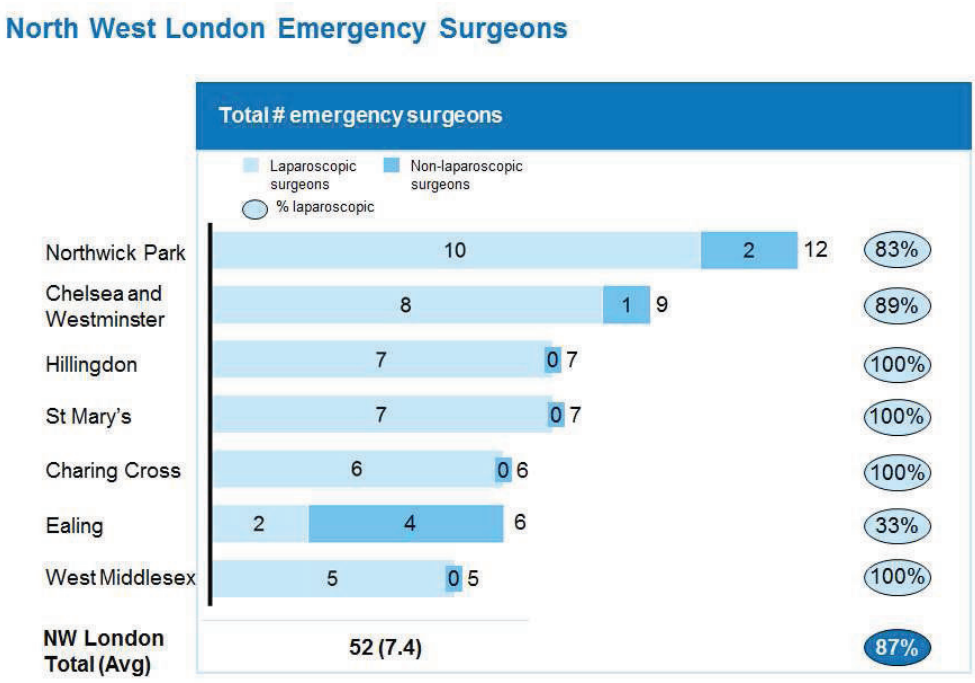
58 Hall B, Hsiao E, Majercik S, Hirbe M and Hamilton B, The Impact of Surgeon Specialization on Patient Mortality: Examination of a Continuous Herfindahl-Hirschman Index; Annals of Surgery, 200

59 Chowdhury M, Dagash H and Pierro A, A systematic review of the impact of volume of surgery and specialization on patient outcome; British Journal of Surgery, 2007

And by being located in specialist centres and working as part of a network of specialist staff, they can access the best equipment and develop their skills by working alongside other specialists.

There are some excellent specialist centres and networks already benefitting patients and carers in NW London. However, there are other areas of clinical practice which would also benefit by being centralised in a few centres of excellence, such as specialist laparoscopic or keyhole surgery[60,61]. Laparoscopic surgery is associated with faster recovery times and can improve patient outcomes, yet at Ealing Hospital only a third of surgeons providing emergency care are able to perform laparoscopic surgery.

NW London Emergency Surgeons[62]



Source: London Health Programmes, NHS London, "Adult emergency services: Acute medicine and emergency general surgery" Report, September 2011

With increasing specialisation and guidelines setting standards for the degree of experience staff need to get to be sufficiently qualified, it is becoming increasingly difficult for the NHS in NW London to sustain the specialist surgical teams needed and ensure they see the volume of cases to enable surgeons to maintain their specialist skills across all our current sites.

There are a high number of sites with smaller staff teams. This results in patients not being assessed and treated by a specialist with the right experience. For example, in emergency surgery, the Royal College of Surgeons (RCS) has noted that a hospital delivering urgent surgery should have a population catchment area of around 450,000 – 500,000 to achieve the volume and case mix necessary to maintain the clinical skills of teams delivering emergency medical and surgical care, given the effect of sub-specialisation[63].

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60 NHS London, Adult emergency services: acute medicine and emergency general surgery, NHS London, 2011

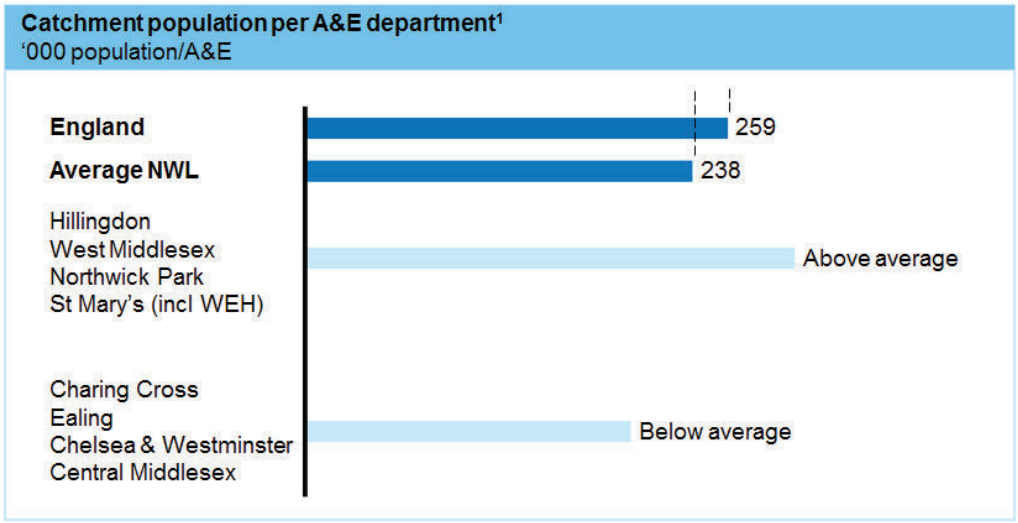
61 Profile of health and services in South West London, Report of the Clinical Working Groups, July 2011

62 Trusts in NW London are working to address issues identified in this report and have made significant progress. For example Chelsea and Westminster now have added surgical capacity to allow 24/7 consultant cover for providing laparoscopic surgery

63 RCS Delivering High Quality Surgical Services (200

With NW London's population of 2 million it is increasingly hard to provide a broad range of services around the clock at nine sites to the standards we believe our population should expect. We have more A&E departments per head of population than other parts of the country and this makes it harder to ensure enough senior staff are available. In NW London the average catchment areas of our A&E sites are below the national average and all, with the exception of Northwick Park, are below the Royal College of Surgeons preferred level.

A&E provision for North West London



1 Assumes 200 A&Es in England; Includes small, medium, large, teaching and multi-service acute Trusts, excludes specialist Trusts; sites with over 10,000 admissions; Assumes Hammersmith catchment travels to St. Mary's; Estimated catchment populations for individual trusts in NWL; England populations ONS mid-2009 estimates;

Source: Estates Return Information Collection, 2010/11; ONS

Other very specialist services – cardiology, oncology (cancer), vascular surgery and neurosurgery – need to be delivered in larger centres of excellence with specialist staff, equipment and facilities. This allows the workforce to train and maintain their expert skills and to utilise specialist facilities and equipment to deliver high quality outcomes.

Residents of NW London currently enjoy excellent access to acute services, with travel times between hospitals being relatively short in comparison to other areas of the UK. Our analysis suggests that we should be able to change where and how urgent care is delivered without significantly impacting how long it takes an ambulance to take a patient to hospital. We are certain that travel times will still be well within accepted limits.

Furthermore, medical evidence clearly indicates that for life-threatening conditions – for example a heart attack, stroke or major trauma – the clinical outcome is far more dependent on getting to the right specialist service than it is on small differences in travel times. Indeed NHS London has already implemented pathways of care that take patients with major trauma, acute heart attack or stroke to designated centres, even if that means going past another hospital. The clinical benefit, in terms of improved survival and reduced disability from the implementation of these pathways, has been proven. If high quality hospital care is to be delivered, there is a clear need to consolidate some services in North West London.

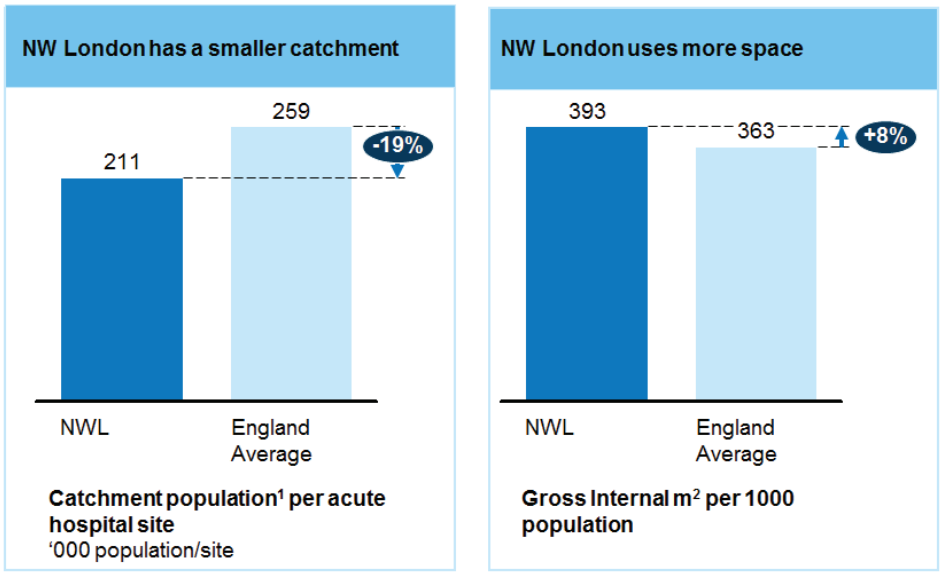
5. Providers face significant estates and financial challenges

5.1 NW London's NHS hospital estate needs £150m investment at the same time as additional investment is needed for primary and community care facilities

The NHS is facing challenges not just in terms of the way it manages and delivers care in NW London, but also in terms of the facilities within which it delivers that care – NHS buildings in NW London are, generally, not in good shape.

First, NW London spends more on hospital buildings than the NHS does in other parts of the country and, as a result, spends less in the community. The space per bed is approximately 50% larger than the rest of the country, and consequently there are higher fixed costs and they are more expensive to run and maintain than average.

Size and use of estate



Includes small, medium, large, teaching and multi-service acute Trusts, excludes specialist Trusts; sites with over 10,000 admissions
1 Estimated catchment populations for individual trusts in NWL; England populations ONS mid-2009 estimates;

Source: Estates Return Information Collection, 2010/11; ONS

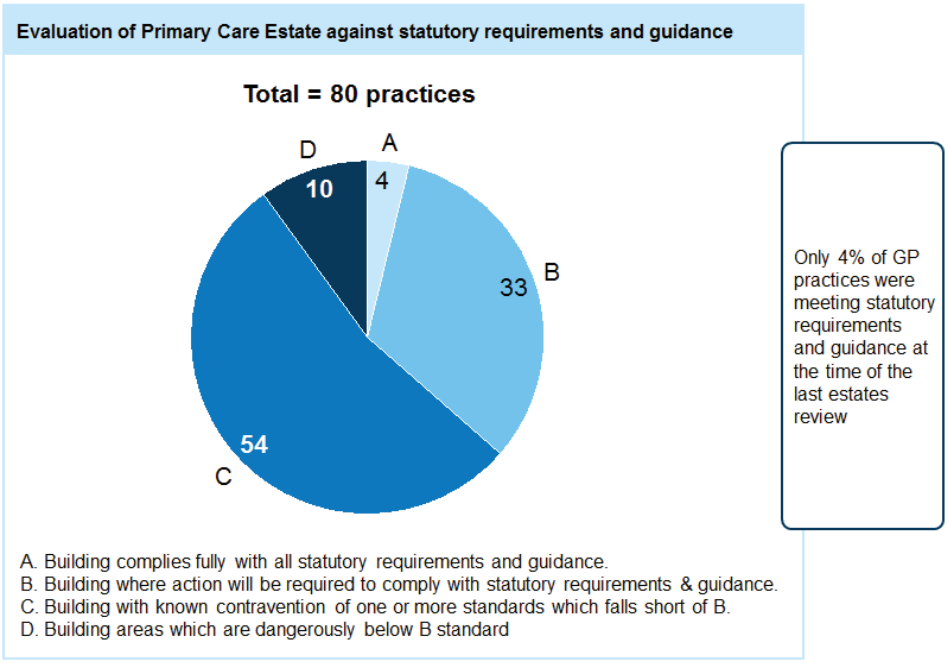
This is not a good use of space in an expensive, densely populated area like London. It is not a good use of NHS resources and is part of the reason NW London currently spends 10% more per capita on hospital care than other parts of the country.

Despite having three newly built hospitals (Central Middlesex, Chelsea and Westminster and West Middlesex), the physical condition of much of the NHS estate here is poor. Currently three quarters of hospitals in NW London require significant investment and refurbishment to meet modern standards, at an estimated cost of approximately £150m[64]. We need to prioritise where we invest to maximum effect as capital funding is a scarce resource. This is particularly important because centralising services will require investment.

[64] ERIC Site-level data, HEFS, 2010/11 (http://www.[illegible]s/DataFiles.asp)

In addition primary and community care requires further investment. Many of NW London's GP practices do not fully meet statutory requirements and guidelines. For instance, GP practices in Ealing would require £6.5m investment to meet these standards – an average of £81,000 per practice[65].

Primary Care Estate – Example: Ealing Borough



Source: Ealing Facet Surveys 2008/9 summary findings, Ingleton Wood

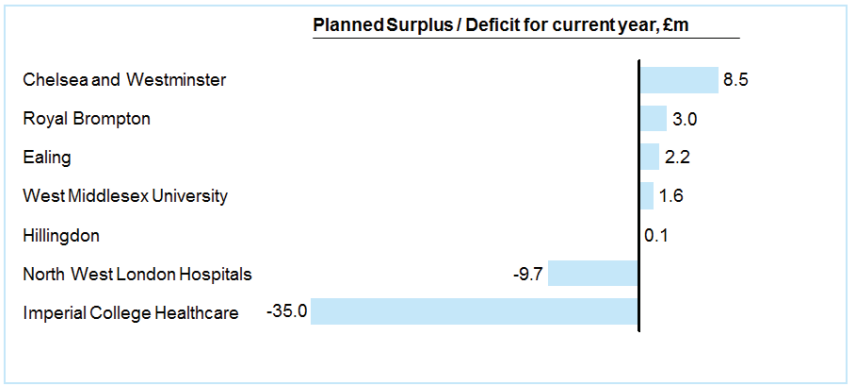
5.2 Our hospitals face extreme financial pressures

As well as their physical condition, many hospitals in NW London are facing acute financial challenges – three are currently in underlying financial deficit and this is likely to get worse.

While there are a number of financially high performing hospitals including Chelsea and Westminster, Royal Brompton and Harefield, and the Royal Marsden, others in NW London struggle to operate within their means. Imperial College Healthcare Trust and NW London Hospitals Trust are projecting deficits for this financial year and several other trusts are facing challenges which are likely to lead to deterioration in their position in the future.

[65] Ealing Facet Surveys 2008/9 summary findings, Ingleton Wood

Several of the acute providers in NW London were already in deficit in 2010/11 and are facing further financial challenges this year
2011/12



The NHS is receiving no increases in funding during 2011/12 so providers are required to make savings in order to offset cost inflation

Source: Trust Finance

There needs to be a hard look at the way services across this part of London are organised if high quality services are to be delivered in future in a financially sustainable way.

This is not just because of funding constraints on the NHS – the boroughs in NW London spend more on healthcare overall than elsewhere in the country and spend more on acute hospitals per head of population than anywhere in the country, both on cost per case and in total spending.

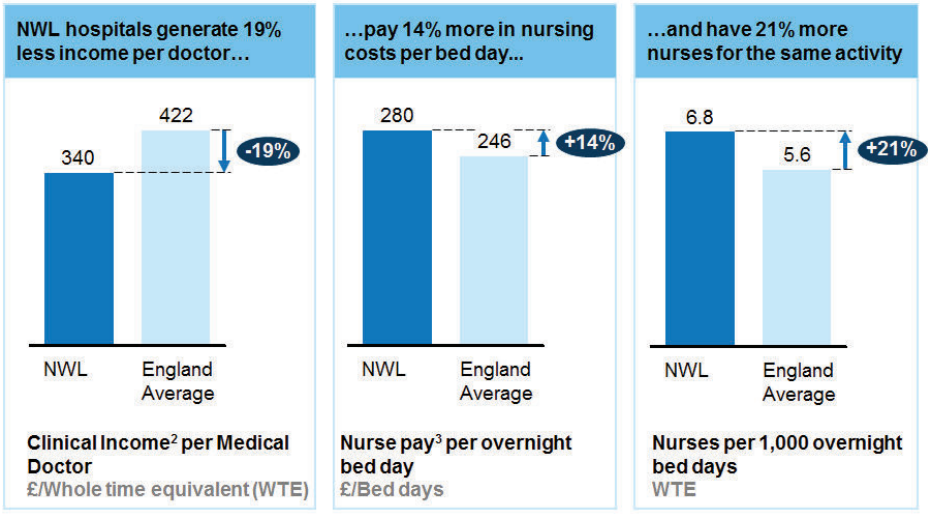
Rather, the financial problems are caused by the previously noted problem of serving typically smaller populations and therefore having a cost per case that is much higher. This makes it relatively expensive to meet staffing guidelines which are often independent of the size of the hospital (for example, College of Emergency Medicine guidelines that 10 whole time equivalent consultants as a minimum in every emergency department independent of size).

Added to this, some processes in NW London hospitals are simply not as efficient as they need to be. For example, planned surgery appointments are often cancelled on the day because emergencies in other parts of the hospital take priority. In 2010/11, many operations in NW London were cancelled on the day of the operation for non-clinical reasons such as this[66]. This is distressing for patients and carers and wasteful in terms of the resources needed to reschedule appointments.

A detailed examination of the current level of productivity of our hospitals shows we have a big improvement opportunity. Doctor productivity (as measured by hospital clinical income per doctor) is close to 20% lower than average and it takes 20% more nurses to deliver our clinical activity than we might expect. But even if our hospitals can achieve these productivity gains, the way we are organised means they will still struggle to break even.

[66] Department of Health

Acute[1] hospitals in North West London generate less income per doctor than average, and have higher nurse costs and more nurses per bed day



1 Acute hospitals, excluding mental health and specialist trusts
2 Excludes Market Forces Factor to make income comparable between hospitals
3 Excludes High Cost of Living Supplement that Nurses receive in expensive areas such as London

Source: HES 2010/11

6. Rising to the challenge

In order to meet these challenges and improve the quality of care provided across NW London, we believe we need to 'reconfigure' our services and change the way they are currently provided across our hospitals, GP practices and other community care sites. This will mean we will need to review the current pattern of hospitals in NW London.

We need to ensure that people in NW London have access to the right care in the right places. Higher quality, more effective treatments for patients need to be provided more consistently where they are needed, within higher quality, more up-to-date, safer places. Care needs to be provided in a more integrated way, in partnership with social services and local government, so that it is clear to patients who is managing their care and that they can seamlessly transition between care settings.

More investment needs to be made in GP services and other local healthcare, so it is more consistent and of a higher standard, bringing better routine treatments closer to home and supporting more services outside hospitals, where they are needed. Alongside this, clinical teams need to be established so patients needing specialist treatment can be certain they will be seen by experienced specialist clinicians, who are familiar with, and who regularly treat, similar patients with their condition.

This also implies more efficient use of NHS buildings and equipment and more targeted investment in both, as well as reduced management costs by planning care across a larger area and achieving savings on a larger scale.

Redesigning services, in the ways outlined above, will enable us to improve the quality of services and increase life expectancy within the resources available.

Our commitments to you once we have made these changes are that:

- You can be supported to take better care of yourself, lead a healthier lifestyle, understand where and when you can get treatment if you have a problem, understand different treatment options and better manage your own conditions with the support of healthcare professionals if you wish;
- When you have an urgent healthcare need, you can easily access a primary care clinician 24 hours a day, seven days a week by telephone, email and face-to-face consultations in local, easily accessible facilities;
- If you need to see a specialist or receive support from community or social care services, this will be organised in a timely way and GPs will be responsible for co-ordinating the delivery of your healthcare;
- If you need to be admitted to hospital, it will be to a properly maintained and up-to-date facility where you receive care delivered by highly trained specialists, available seven days a week, with the specific skills needed to treat you.

NW London has recently launched a programme to develop the options for service configuration together with local hospital, GP and community providers with the aim of identifying options for improving the configuration for public consultation, starting in June 2012.

In many ways, the case for making these urgent changes is compelling. In practice, there are understandable local loyalties to having services as close to home as possible and change can be difficult to achieve. It is imperative that we collectively work together to make changes that improve the standard of care for our local population.

But we need to make changes urgently. We can either keep a model of NHS care that will inexorably fall behind the rest of the country and the needs of our patients, or try to change things now and offer all members of our society the best care we can give them.

This is about the future, not the present. It is about saving lives, not money. By implementing these changes, we will save lives in NW London. The value of the NHS is not just about physical buildings, but about the collective skills and resources that need to be managed and properly planned, now, to offer the next generation even better care than we offer at present.

Letter: NHS change must be driven by clinical evidence[67]

There has been a wealth of clinical evidence for many years that specialist clinical services, such as stroke, trauma and heart surgery, should be concentrated in fewer centres. This would allow the latest equipment to be sited with a critical mass of expert clinicians who regularly manage these challenging clinical problems, and are backed by the most up-to-date research. The greater volumes of patients mean doctors are better at spotting problems and treating them quickly.

Survival and recovery rates would improve markedly with many lives saved. As techniques and technology have developed over recent years, specialty rather than proximity has become the key for patient safety. So increased patient safety and improved care must be the major drivers of any reconfiguration.

Patients may indeed have to travel further for some specialist care, but if it is significantly better care then we believe that centralisation is justified.

However, at the same time there is also strong evidence to support a large amount of more routine care, currently taking place in hospitals, being carried out closer to where patients live in the community with GPs playing a crucial role in the delivery of services.

Delivering this requires strong leadership and brave decision-making from doctors, managers and politicians. Simply condemning change as bad and defending the status quo as ideal is not serving the interests of patients.

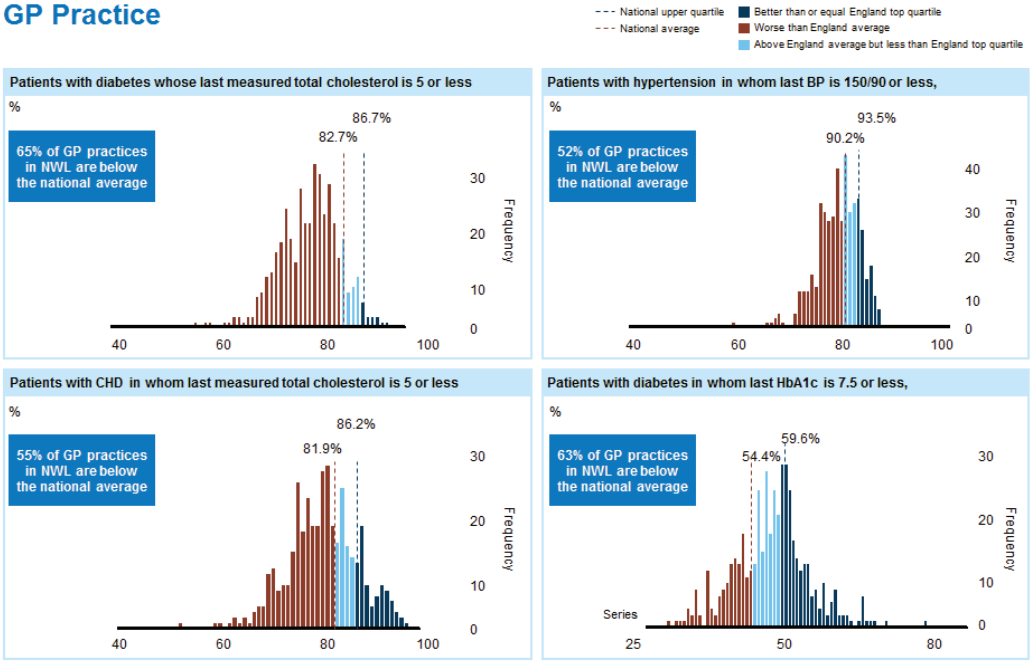
Signed by all the Presidents of the following organisations at the time: *Academy of Medical Royal Colleges, Royal College of Physicians, Royal College General Practitioners, NHS Confederation, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics & Child Health, Royal College of Psychiatrists, Royal College of Anaesthetists, Royal College of Radiologists, Royal College of Ophthalmologists, Faculty of Public Health Medicine, Faculty of Pharmaceutical Medicine, Faculty of Occupational Health*

[67] Extract from a letter that appeared in The Guardian on the 28 April 2010, quoted in Safe and Sustainable: a new vision for children's congenital heart services in England, Consultation Document - 1 March 2011 to 1 July 2011

Appendix

Diagram 1

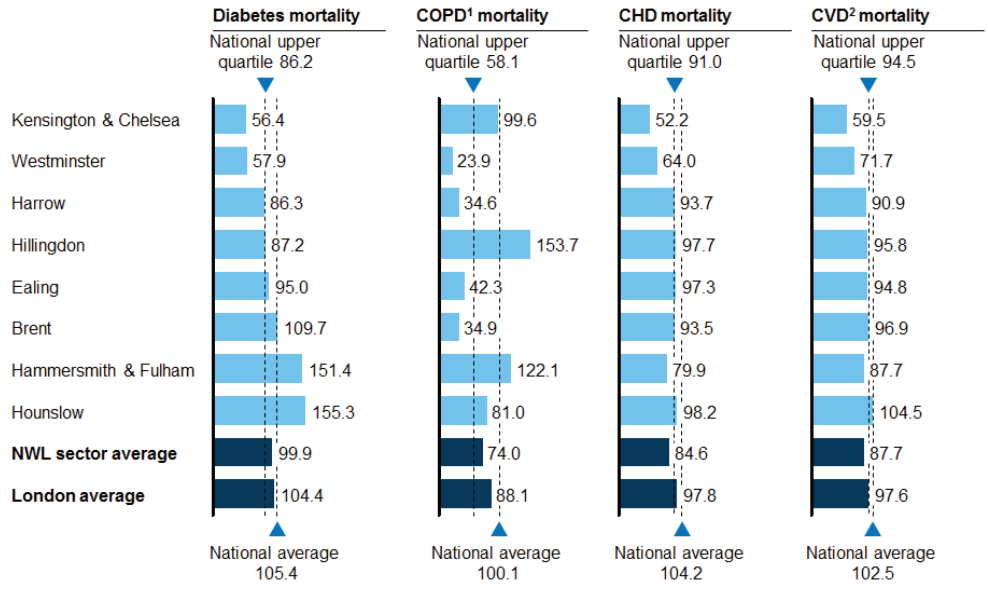
Management of patients with Long Term Conditions varies significantly by GP Practice



Source: QOF 2009–10 GP data tables DM17; CHD6; CHD8; DM23

Diagram 2

Standardised Mortality Ratios for patients with LTCs across NW London



1 Mortality from bronchitis, emphysema and other COPD
2 Mortality from all circulatory diseases

Source: Standardised mortality ratio, NCHOD, 2007–09, all ages

Diagram 3

Primary care patient satisfaction scores for communication and access are poor compared to the rest of the country

% Patients reporting satisfaction 2010/11

Top 10%
Top 10–25%
Top 25–50%
Bottom 10–50%
Bottom 10%

	Communication		Access	
	Satisfaction with doctor communication and empathy skills[2]	Satisfaction with nurse communication and empathy skills[3]	Satisfaction with out of hours service[4]	Satisfaction with waiting time in surgery[1]
Brent	75.4	62.4	51.2	53.8
Ealing	74.7	60.6	52.5	57.7
Hammersmith & Fulham	78.0	57.1	54.8	64.1
Harrow	78.4	62.1	56.3	57.8
Hillingdon	76.2	64.1	52.3	71.5
Hounslow	75.1	61.2	46.5	60.0
Kensington & Chelsea	79.7	60.8	62.8	67.7
Westminster	76.6	62.3	58.3	60.4
National Avg.	82.0	67.1	67.1	69.5

1 Percentage of patients seen at scheduled appointment time or waiting less than 15 minutes.
2 Average percentage of patients rating their care to be 'very good' or 'good' for the following categories: Doctor giving patient enough time; asking patient about symptoms; listening to patient; explaining test and treatments to patient; involving patient in decisions about care; treating patient with care and concern; taking patient's problems seriously.
3 Average percentage of patients rating their care to be 'very good' or 'good' for the following categories: Nurse giving patient enough time; asking patient about symptoms; listening to patient; explaining test and treatments to patient; involving patient in decisions about care; treating patient with care and concern; taking patient's problems seriously.
4 Average percentage of patients rating the ease of contacting out-of-hours service by telephone as 'very easy' or 'fairly easy', the timeliness of care received as 'about right', and the care received from out-of-hours service as 'very good' or 'good'.

Source: GP Patient Survey 2010/2011

Diagram 4

Inpatient satisfaction scores are average or below average for all NWL hospitals aside from specialist hospitals

Patient satisfaction score out of 10, 2010

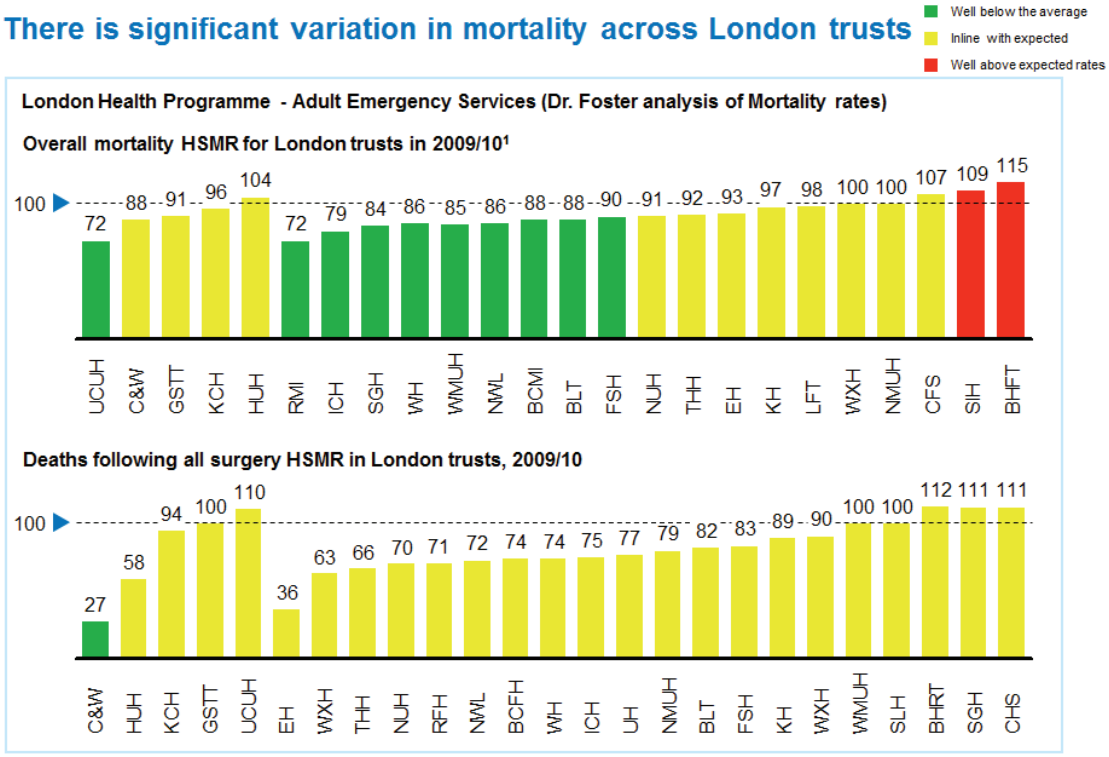
Higher[1]
Lower[1]
About the same[1]

	Patient Satisfaction					
	A&E services	The hospital and ward	Doctors	Nurses	Care and treatment	Overall experience
Chelsea & Westminster Hospital	7.4	7.5	8.4	7.5	7.2	6.4
Ealing Hospital	7.0	7.6	7.9	7.6	7.0	6.1
North West London	7.0	7.7	8.1	7.8	6.8	6.0
Royal Brompton	N/A	8.5	8.9	8.9	8.2	7.5
Royal National Orthopaedic Hospital	N/A	8.3	9.1	8.7	7.8	7.1
Hillingdon Hospital	6.9	7.8	8.1	7.8	6.9	6.3
The Royal Marsden	N/A	8.6	9.4	9.1	8.4	7.1
West Middlesex University Hospital	7.3	7.9	8.3	7.8	7.0	6.1
Imperial College Healthcare	7.6	8.0	8.4	8.1	7.3	6.8
National Avg.	~ 7	~8	~8	~8	~7	~6

1 Compared to other trusts in England

Source: Care Quality Commission – Patient satisfaction survey 2010

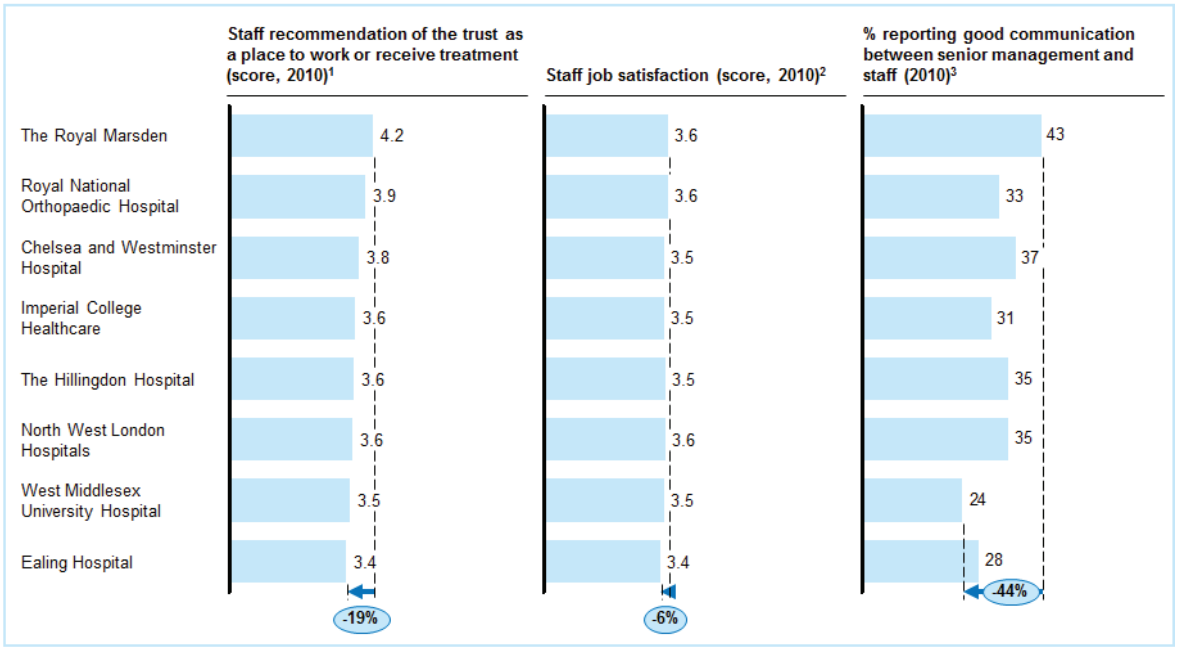
Diagram 5



1 Trusts are grouped according to foundation status as per Dr. Foster groupings

Source: AES-Case-for-change-September-2011; Dr. Foster Ltd.

Diagram 6



1 2010 National NHS staff survey – Care Quality Commission, KF34 (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree)

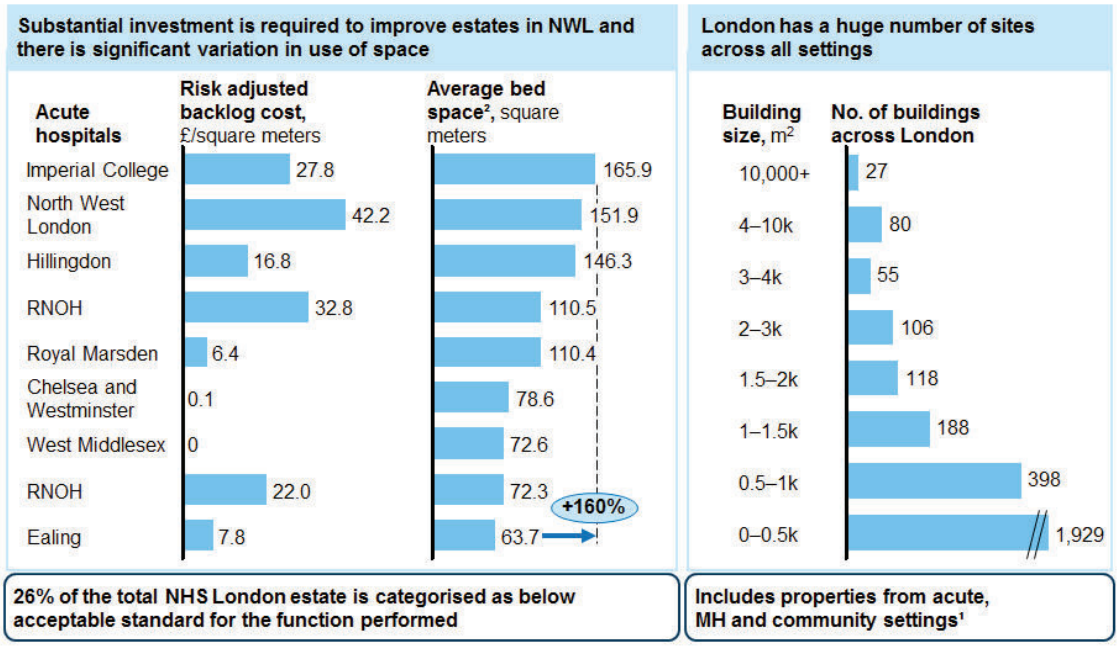
2 2010 National NHS staff survey – Care Quality Commission, KF32

3 2010 National NHS staff survey – Care Quality Commission, KF30

Diagram 7

In addition existing estates have large maintenance backlogs

BASED ON DATA PROVIDED BY TRUSTS

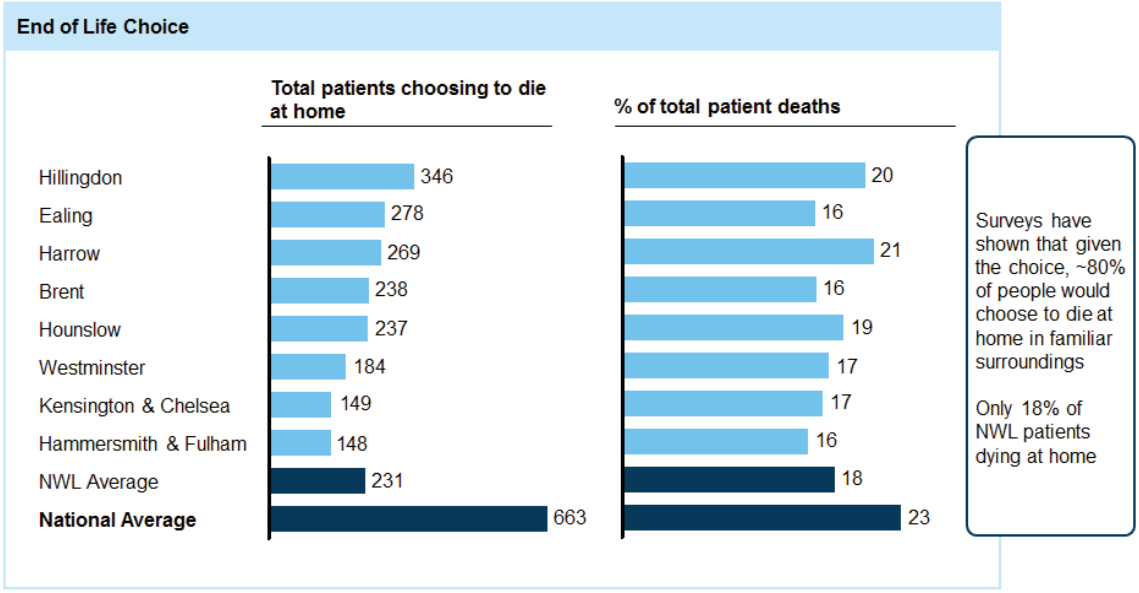


1 Includes properties owned by PCTs, Acute Trusts and Mental Health Trusts, excludes GP-owned practices and LIFT buildings (45 in total)
2 Patient occupied space divided by number of beds
Source: Estates Returns Information Collection (ERIC), 2008-09; team analysis

Diagram 8

Only 18% of patients in NWL are dying in familiar surroundings at home; this falls 5% below the national average.

% of patients dying at chosen location



Note: Total patients dying at home is defined as "Deaths at home from all causes, classified by underlying cause of death (ICD 10 A00-Y99), registered in the respective calendar year(s)". Data pooled between 2005/6- 2009/10.

Source: National Centre for Health Outcomes Development - Compendium indicators 2010-2011

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