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Health Partnerships Overview and Scrutiny Committee

Wednesday 18 July 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)	Cheese	Ms Shaw
Colwill	Baker	Kansagra
Gladbaum	Ketan Sheth	Van Kalwala
Harrison	Naheerathan	Singh
Hector	Aden	Al-Ebadi
Hossain	Ogunro	RS Patel
Leaman	Sneddon	Clues

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The press and public are welcome to attend this meeting

Agenda

Introductions, if appropriate.

Apologies for absence and clarification of alternate members

Item Page

1 Declarations of personal and prejudicial interests

Members are invited to declare at this stage of the meeting, any relevant financial or other interest in the items on this agenda.

2 Deputations (if any)

3 Minutes of the previous meeting held on 30 May 2012 1 - 12

The minutes are attached.

4 Matters arising (if any)

5 Brent Improving Access to Psychological Therapies Service 13 - 14

The Health Partnerships Overview and Scrutiny Committee has been keen to carry out more scrutiny of mental health services in Brent. Clearly this is an important area, but one that has been overlooked by the committee in recent years as it has focussed attention elsewhere. In order to introduce councillors to mental health provision in Brent, a presentation will be given at the committee on Brent's Improving Access to Psychological Therapies Service (IAPT).

A copy of the presentation for Members is enclosed separately.

6 Care UK Serious Incident 15 - 28

A report detailing the results of the investigation into the serious incident at Central Middlesex Hospital and the subsequent action plan drawn up are attached.

7 North West London Hospitals NHS Trust and Ealing Hospital NHS Trust merger - Full Business Case 29 - 76

The reports are attached.

8 Shaping a healthier future consultation 77 - 164

The reports are attached which outline the three main options being considered.

9 Brent Tobacco Control Service - progress report 165 - 198

NHS Brent has provided an update on the Tobacco Control work taking place in the borough. Three separate papers have been provided for the committee to consider and scrutinise:

(i) Tobacco Control Progress Report
(ii) NHS Brent Stop Smoking Service Update
(iii) Clear Thinking - CLeaR Model Assessment for Excellence in Local Tobacco Control - London Borough of Brent

10 Kenton Medical Centre update - information item 199 - 202

The report updates Members with regard to former patients of Kenton Medical Centre and is for information only.

11 Health Partnerships Overview and Scrutiny Committee work programme 203 - 210

The work programme is attached.

12 Any other urgent business

Notice of items to be raised under this heading must be given in writing to the Democratic Services Manager or his representative before the meeting in accordance with Standing Order 64.

13 Date of next meeting

The next meeting of the Health Partnerships Overview and Scrutiny Committee is scheduled for Tuesday, 9 October 2012 at 7.00 pm.

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

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Wednesday 30 May 2012 at 7.00 pm

PRESENT: Councillor Kabir (Chair), Councillor Hunter (Vice-Chair) and Councillors Al-Ebadi (alternate for Councillor Hector) Daly, Harrison, Hector, Hossain and Leaman

Also present: Councillors Cheese, Hashmi, Mistry (Lead Member for Adults and Health) and McLennan

Apologies for absence were received from: Councillors Colwill and Hector

Others present: Colin Babb (Brent LINk), David Cheesman (North West London Hospitals Trust), Andrew Davies (Brent Council), Rachel Donovan (NHS North West London), Maurice Hoffman (Brent LINk), Toby Howes (Brent Council), Paul Jankcowiak (North West London Hospitals NHS Trust), Jacinth Jeffers (Community Services Brent , Ealing NHS Trust), Rob Larkman (NHS Brent and Harrow), Yvonne Leese (Ealing Hospitals NHS Trust), Jo Ohlson (NHS Brent), Sunil Patel (LPG Brent), Mansukh Raichura (Chair, Brent LINk), Phil Sealy (Brent LINk), (Brent Jeff Zitron (NHS North West London)

1. **Declarations of personal and prejudicial interests**

None declared.

2. **Minutes of the previous meeting held on 27 March 2012**

RESOLVED:-

that the minutes of the previous meeting held on 27 March 2012 be approved as an accurate record of the meeting.

3. **Matters arising (if any)**

Recruitment of health visitors in Brent

Councillor Hunter commented that a written answer was awaited in respect of her query concerning domestic violence. Phil Newby (Director of Strategy, Partnerships and Improvement) replied that he would request that Genny Renard (Head of Community Safety - Integrated Community Safety, Strategy, Partnerships and Improvement) to provide some information.

4. **Recruitment of health visitors in Brent**

Yvonne Leese (Ealing Hospital NHS Trust) introduced this item and advised that there was a shortage of health visitors both locally and nationally. The Trust was developing a recruitment and retention strategy and some progress was already being made in recruiting health visitors.

Jacinth Jeffers (Community Services Brent, Ealing NHS Trust) then presented the report and advised that a task and finish group had been created in June 2011 to progress the Department of Health paper, 'health visitor implementation plan – a call to action.' She referred to the table in the report outlining the vacant health visitor posts over the last two years, which had averaged twelve vacancies consistently despite a recruitment drive. Jacinth Jeffers advised that the most recent external recruitment exercise had shortlisted six applicants and resulted in five of these accepting job offers. Community Services Brent had also offered health visitor posts to internal students subject to them qualifying in September 2012. However, the committee heard that it was not compulsory for students to remain with the Trust once they had qualified, so it was important that students were well supported and encouraged to take up posts in Brent. In total, ten health visitor posts were due to be filled in September 2012. However, it was forecast that a further 43 additional health visitors would be required by 2015.

During discussion, Councillor Harrison enquired whether the Trust was limited to the number of students it could recruit each year. Councillor Hunter asked whether the Trust was confident that it could recruit the number of health visitors required in 2015 and what incentives were in place to encourage recruitment and retention of staff. Councillor Leaman commented that recruitment of health visitors had been a long standing problem and he asked whether exit interviews were conducted for those leaving and what were the specific problems in Brent. He also enquired what impact under capacity was having on staff and was it affecting morale. Councillor Daly asked how many health visitors were currently in post and what was the intended total number to recruit for this year and whether the ethnic mix of the staff reflected Brent's population. She also asked if there was a gap in service in view that vacancies remained. Councillor Al-Ebadi sought clarification as to whether back staff had the appropriate qualifications.

The Chair asked whether there were sufficient financial resources to cover the forecast recruitment required in the next few years and was there any kind of guarantee that the students would remain with the Trust once they had qualified. She also asked if there were an adequate number of practice teachers to train students.

In reply to the issues raised, Jacinth Jeffers advised that funds had been committed this year for the recruitment required, however funding was agreed on an annual basis with the NHS and the Trust had been funded to take on five students this year. The Trust was currently considering what incentives it could introduce to encourage recruitment and retention of staff, including analysing what motivated them, such as offering new streams that they could specialise in. Jacinth Jeffers advised that exit interviews of departing staff was undertaken and the reasons why they were leaving varied, including retirement, however sometimes staff simply wished to reduce the hours they were doing. Members heard that there were currently 29 health visitors in post and some vacancies were covered by back staff who were appropriately qualified. There was funding to recruit an additional 16 staff in total this year. The staff ethnic mix was fairly diverse and the Trust was working with NHS London to target first generations of particular ethnic groups, such as Somalians. Jacinth Jeffers acknowledged that under staffing was an issue and that its effects on staff was being closely monitored, including engaging staff through effective communication, including through staff forums and it was important that

staff were aware of the Trust's future plans. Although there was a sufficient number of practice teachers, it was always desirable to have more and the addition of two more in September would mean that there would be five teachers in total.

Yvonne Leese added that there were separate funding channels to recruit the additional qualified health visitors and to take on students in September. As there was no present requirement for students to remain with their respective Trust after qualifying, it was important that they were given a good work experience and support to encourage them to remain. There had been vacancies at the Trust for the last four years despite funding being available to recruit for these posts. Yvonne Leese advised that there was a London-wide shortage of qualified and experienced health visitors. The long term solution involved supporting new students and attracting as many maternity placement nurses as possible, including those presently out of service. However, the Trust did benefit from a low turnover with a committed group of health visitors and the main problem was in recruiting new staff as opposed to retention. The committee heard that six vacancies were currently covered by back staff, with a further six remaining unfilled. The Trust also had to prioritise particular areas, such as new births, those that involved vulnerable children or in need and those on the protection register, which meant that not as much resources could be focused on health promotion than would otherwise be desirable.

The Chair asked that the committee be provided with an update on recruitment and retention figures and training in around six months.

5. **Accident and Emergency waiting times**

Paul Jankowiak (North West London Hospitals NHS Trust) introduced the report which set out Accident and Emergency (A and E) waiting times over the last six months. He began by advising that the Department of Health's NHS Performance Management Framework set out a performance indicator that required 95% patients to be seen within four hours. He referred the table in the report outlining the performance of Central Middlesex Hospital, Northwick Park Hospital and the Trust overall. Paul Jankowiak advised that the targets were being met consistently since March 2012.

Councillor Daly sought confirmation that Northwick Park hospital received the largest number of A and E visitors and in noting that some patients had been waiting too long in February and March, she asked how they were dealt with. She also asked for further data with regard to what happened to A and E patients when they arrived, including how many had arrived by ambulance and those who were seriously ill. Councillor Daly asked if there were specific plans in place in respect of the Olympics. Councillor Leaman asked for further details about waiting times for those patients who had to wait longer than four hours to be seen.

The Chair enquired why ambulance transfer times had not been provided as this had been the committee's wish.

With the approval of the Chair, Councillor Cheese also addressed the committee and commented that the ambulance service would be under additional pressure during the Olympics, especially those ambulances needing to do patient transfers via Wembley and he enquired what steps were in place to address this. Maurice

Hoffman (Brent LINk) also addressed the committee and he enquired whether the average A and E waiting times were in effect being lowered by the Urgent Care Centres (UCC) and did waiting times vary depending on the time of day.

In reply, Paul Jankowiak explained that he thought it was the number of transfers being on target that were of particular interest to the committee and he stated that information could be provided on ambulance transfer times. Those who were deemed seriously ill received treatment within four hours. Paul Jankowiak confirmed that waiting times did include those patients treated by the UCCs and waiting times increased in the early hours of the morning and late evening.

David Cheesman (North West London Hospitals Trust) added that the UCC was effectively part of the same department as A and E and waiting times were also affected depending on the time of year, particularly during winter and capacity was scheduled accordingly. He advised that Northwick Park hospital had struggled with rising demand initially, however recent improvements in how it handled A and E cases were reflected in a boost to performance. Nurses would decide whether patients needed to go to A and E or treated at the UCC and patients categorised as 'type one' would go to A and E. David Cheesman explained that the waiting times were calculated from the moment the patient entered the hospital and he confirmed that a breakdown of figures with regard to waiting times including ambulance transfer times and those arriving by ambulance could be provided. Members noted that a large number of patients, for example, were submitted to the Stroke Clinic. David Cheesman advised that a number of measures were in place in respect of the Olympics and annual leave requests were being monitored during this period, whilst staff accommodation was also available on all sites. He acknowledged that the ambulance service could potentially be under more strain during the Olympics and the service was involved in planning for this period to ensure a resilient service could be provided. Members heard that figures were not immediately available regarding how long patients had waited where they had not been seen within four hours, however there were no examples of it exceeding 12 hours, which nationally was deemed as unacceptable.

The Chair requested that information be sent to Andrew Davies (Policy Officer, Strategy, Partnerships and Improvement) with regard to the number of ambulance transfers and their transfer times for Central Middlesex and Northwick Park hospitals.

6. **Shaping a healthier future - Brent out of hospital care strategy and an update on the North West London Joint Overview and Scrutiny Committee**

Rob Larkman (Chief Executive, NHS Brent and Harrow) introduced the report and explained that there were two main elements to shaping a healthier future, these being the future hospital-based acute services and developing a strategy for out of hospital services. Consultation on proposals would continue until October 2012.

Dr Tim Spicer (Shaping a Healthier Future) then presented further detail in the report. Following on from the two main elements of the programme, he referred to the particular challenges for North West London, which included a projected increase in population of 113,000 in the next ten years, whilst the population also continued to age with 31% having long term chronic conditions. Dr Tim Spice drew Members' attention to the variations within hospital care and the differing outcomes

of patients as set out in the report. With regard to developing an out of hospital care strategy, this would apply to each of the North West London boroughs and key themes were emerging from these. There would also be the establishment of four standards to maintain quality of care, these being:-

- Individual patient empowerment and self care
- Service access convenience and responsiveness
- Care planning and multi-disciplinary care delivery through a joined-up approach
- Standards of information and communication sharing

Dr Tim Spicer advised that the strategy would go public and UK standards would be used to model finances. Every effort would be made to demonstrate how the drive for changes would be made and it was intended to create coherence and confidence in the service whilst relieving stress on acute services.

Ethie Kong (Clinical Commissioning Group Chair, Brent) added that a borough level view was also being considered with regard to how the strategy would be delivered locally and how the local vision would change in the next three years.

Jo Ohlson (Brent Borough Director, NHS Brent and Harrow) advised that plans for outside of hospital care had been developed in the last two years and she cited the Short Term Assessment, Reablement and Rehabilitation Service (STARRS) as an example and which had achieved high satisfactory rates in providing services in the community.

During discussion by Members, Councillor Harrison commented that access to services was an issue and the reforms proposed placed a lot of focus on the role of GPs. In some cases, GP practices were not sufficiently organised and she asked what steps would be taken to ensure GPs took the appropriate action so that their practices performed to the levels necessary. Councillor Daly sought clarification of the term 'frequent flyers' as she felt it somewhat inappropriate. Councillor Leaman commented that the report did not make mention of the need to change the behaviour of the public to help ensure that the new arrangements would be effective and there needed to be measures in place to promote public awareness. He also asked what information was provided to those who may be first time visitors in accessing health services. Councillor Hunter welcomed the report overall and enquired when the programme was due to go live, however she enquired how confident were the NHS that funding from acute providers would be released to community services. She also sought more information with regard to what consultation would be undertaken and when. Councillor Al-Ebadi noted the present different outcomes for patients as set out in the report and he enquired what steps were being taken to improve these, particularly for groups who currently have poorer outcomes than others.

The Chair commented that Members were putting together a separate list of questions to forward to NHS colleagues with a view to arranging a meeting with them to discuss the issues raised.

With the approval of the Chair, some non-member councillors addressed the committee. Councillor Hashmi commented that in view of the financial pressures,

how would savings be achieved. Councillor Cheese stated that disorganised services could result in patients losing confidence.

In reply to the issues raised, Dr Tim Spicer advised that GPs were required to undertake what they were contracted to do, however more attention was needed as to how they should work with other services. It was intended to provide access to coordinated care services and linking up with social care. Dr Tim Spicer advised that GPs could produce core plans to help achieve better outcomes, whilst the health economy was moving in the direction to reduce hospitalisation and provide more appropriate care where applicable. This also involved a more planned and coordinated approach in providing services in the community. Members heard that patients that had made unnecessary visits to the UCCs were contacted to identify the reasons why they had done so and sign posted as to what would be the most appropriate services to access.

Jo Ohlson advised that 'frequent flyer' was an NHS term for patients who were frequent visitors to A and E and such patients would be identified and steps taken to see if they could be treated more effectively in a different way. It was proposed to improve access to GPs in Brent and with the other North West London boroughs and provide patients with more choice and the focus was in providing the most appropriate care. Investment in staff for community services would improve such services and help reduce hospital admissions and therefore costs in this area.

Ethie Kong commented that changes in how GP services could be accessed were being pursued, including providing appropriate sign posting and a joined up approach with the appropriate organisations was required. She stated that self care was also an important factor in improving outcomes. With regard to unnecessary visits to UCCs, Ethie Kong explained that there was a process of re-direction then education of the patient concerned. She acknowledged that the scheduling of the consultation was of particular importance in order to provide user groups sufficient time to provide feedback, including Brent LINk, and a timetable of consultation would be publicised.

Rob Larkman added that the programme was intended to improve care and provide a sustainable basis whilst also making financial efficiencies.

The Chair requested that information with regard to how the consultation be undertaken, including the timetable, be provided and that any questions Members wished to be forwarded to NHS colleagues to answer at the separate meeting be sent to Andrew Davies.

7. **Primary care update - Willesden Medical Centre, Kenton Medical Centre and Kilburn Medical Centre**

Jo Ohlson introduced the report and confirmed that the lease at Willesden Green Medical Centre expired on 31 August 2012. The two options being looked at involved either the possibility of relocating the centre and also possibly including Dr Fletcher's practice to the Willesden Health and Well Being Centre, or Willesden Green Medical Centre and possibly Dr Fletcher's practice remain at the same premises if the current landlord was able to improve their existing accommodation and provide space for Dr Fletchers' practice. Discussions and meetings were

taking place in respect of these and the committee would be updated about developments.

In respect of Kilburn Medical Centre that had been operating under a temporary contract, it had been decided to terminate this contract on 30 June 2012. NHS Brent had undertaken a review as to whether to develop a specification and tender on the open market or to list dispersal of the registered population. However, as there was no guarantee that a contract would be awarded to a new provider or that the service could remain at the existing site, it was decided to disperse the patient list. Members noted the results of the health inequalities assessment that had been undertaken as part of coming to this decision.

Rachel Donovan (NHS North West London) confirmed that the two doctors at Kenton Medical Centre were retiring and had tendered their resignation for 30 June 2012 and this would also mean the termination of the Personal Medical Service (PMS) contract. Two options had been considered, the first enabling patients to register with a GP from existing list of practices in the area and the second inviting applications from providers to take up a PMS contract at Kenton Medical Centre. Consultation had involved all patients over 16 years of age, local councillors and MPs and this committee. Following this, it had been recommended to the NHS North West London Board that patients be asked to register with an alternative practice in the area as the list of patients to existing GP practices had capacity to register additional patients and gave patients more choice as to where they would like to register. The alternative option was not being pursued as the length of time to procure a new practice on the existing site could take up to twelve months. In addition, the 2,500 patients affected was well below the average practice size. Should the recommendation be approved, the list of practices would be reviewed to ensure that they were ones closest to where patients lived, as opposed to closeness to Kenton Medical Centre. Kenton Medical Centre would also be asked to assist in identifying vulnerable patients and helping them re-register and provide assurance that they have re-registered prior to the practice closing.

During discussion, Councillor Leaman enquired whether the letter sent to patients on 5 April 2012 informing them of the retirement of the GPs at Kenton Medical Centre had also been provided in different languages, particularly as the wording used was not especially clear. Councillor Daly enquired whether patients would still have access to community facilities in Harrow that were available in Brent and felt that this was an issue that needed particular attention.

The Chair enquired what monitoring steps were in place to ensure all Kenton Medical Centre patients were re-registered and whether those transferring to practices in Harrow would have matching social services that they may require. She added that the patients' group were not informed about the situation at Kenton Medical Centre at the last meeting in April.

Councillor McLennan was also invited to address the committee and she commented that services in Harrow were not so enhanced as those provided in Brent and she queried why patients were not being offered more practices in Brent.

Maurice Hoffman also addressed the committee and enquired if demand would be monitored in respect of Kenton Medical Centre's proposed closure as it could affect services and could GP practices also consult Brent LINk.

In reply, Rachel Donovan advised that NHS North West London held the patients registry database and would be able to see what patients had not re-registered. A large number of Kenton Medical Centre patients had already re-registered and those who had not would be monitored and contacted again if they had not re-registered within two weeks. The committee heard that those who had not yet re-registered tended to be patients who visited infrequently. In respect of social services and enhanced services, Rachel Donovan commented that similar GP practices were being looked at in Harrow and Brent and demand would be monitored, whilst Brent LINk could also be kept informed.

Rachel Donovan explained that following the first letter to patients on 5 April with regard to GP practices list which was based on those closest to Kenton Medical Centre, a second letter had subsequently been sent with an extended list that included more that were in Brent and it was noted that a number of patients were located near the border with Harrow. Every effort would be made to ensure any future letters were easier to understand and although neither letter was available in different languages, the second letter had information on what patients could do if they did not understand the letter. Community Services were to be approached with regard to patients who may need such services.

Jo Ohlson added that there had been a reciprocal agreement between Brent and Harrow that patients could register with a GP practice in a different borough providing they were within half a mile of the border with the other borough. However, she acknowledged that this was an issue and it may be more prudent for patients to register with a practice in their own borough.

The Chair requested an update at the next meeting concerning where Kenton Medical Centre patients had re-registered.

8. **Serious incident at Brent Urgent Care Centre**

Jo Ohlson provided an update in respect of a recent serious incident at Central Middlesex Hospital UCC involving patients who had apparently not been discharged from the IT system and therefore it could not be confirmed that those with radiology reports had been reviewed for missed pathology. She advised that most of the patients affected had been contacted promptly once the problem was discovered, and of the 97 patients that had remained outstanding, 76 had subsequently been contacted, with 48 of these requiring no further action. Of the others, fifteen had been offered appointments, six had been re-called at the correct time following the initial x-ray, three referred by GPs to another health facility, three advised to contact their GP and one had sought follow up from a different provider. Of the remaining 21 who had not been contacted, twelve had left no contact details, six had failed to respond. However, three had subsequently been contacted following information provided by their GP. Jo Ohlson advised that of those with no contact details, GPs were being asked if they held any records. A report was due to be published on 6 June to identify how the error had happened.

Councillor Leaman asked how many of the 97 patients involved were children. He asked when the earliest failure to record a case had happened and why had the lack of discharging from the IT system not been picked up earlier. He asked whether NHS Brent had any view at this stage with regard to Care UK's role about

the situation. Councillor Hunter commented that if the build-up of patients who had not been discharged on the IT system had been happening over an extended period of time, then it appeared that there must be a fundamental system failure. She also enquired what specific action had not been done that had resulted in the incident. Councillor Daly expressed concern about the incident and felt the number of patients involved was not acceptable. She felt that NHS Brent had failed to monitor the contract with Care UK properly and she asked what steps were being taken to address this as well as seeking clarification as to who was leading the investigation into the incident. Further explanation was also sought in respect of lack of patient contact details for those affected by the incident.

Mansukh Raichura (Brent LINk) was also invited to comment and he stated that it was important that all departments of the hospital worked closely together to ensure such incidents did not happen in future.

In reply to the issues raised, Jo Ohlson advised that of the 97 patients, four of these were children and it was understood that these had been contacted. The earliest failure to record a case had occurred sometime after the UCC had opened in 2011, although the red cases which were of more concern were much more recent. At this stage, it was no possible to pinpoint the specific reasons for the failure whilst the investigative report was awaited. However Care UK had accepted overall responsibility and their contract was quality monitored by three clinical leads from the Clinical Commissioning Group (CCG) and regular meetings took place with them. The investigation was being led by Care UK and one of the clinical directors. Upon the conclusions of the investigative report, if Care UK were found to be seriously at fault, amongst the options available included financial penalties or even termination of contract. Members noted that the risk of harm to patients affected was very low and that incidents of this sort did happen from time to time in healthcare, although in this particular case once the problem was identified NHS Brent had been informed promptly. With regard to problems contacting patients, this was mainly due to the lack of information that some patients had provided.

The Chair requested that the investigation report due for publication on 6 June be sent to Andrew Davies with a view to including this item for discussion at the next meeting.

9. **Update on the procurement of new community cardiology and ophthalmology services**

Jo Ohlson gave a brief introduction to the report that was before Members updating them on the public consultation of the procurement of the new community cardiology and ophthalmology services.

Councillor Daly enquired what action would be taken following the consultation. Councillor Hunter stated that she had not seen any consultation letters to date and she enquired why consultation on cardiology and ophthalmology services were being undertaken together as they were two significantly different kinds of services.

The Chair suggested that there should be separate consultation questionnaires for cardiology services and ophthalmology services and she enquired what patient groups were being consulted. She also sought confirmation as to what body would make the final decision.

Maurice Hoffman was invited to address the committee and he commented that Brent LINk were still awaiting responses to two letters they had sent NHS Brent with regard to this issue. He queried why the consultation was being undertaken simultaneously for both cardiology and ophthalmology services as there were no obvious connection between the two. He felt that patients and stakeholders had not been adequately consulted, whilst a request to postpone consultation in order to increase public involvement had not been responded to.

In response, Jo Ohlson advised that the consultation was with regard to service specification which had been under consideration for some time and no service was to be de-commissioned. Jo Ohlson indicated that she would take on board comments made with regard to how the consultation should be undertaken and respond accordingly. Members noted that following consideration of the consultation and a response to it, recommendations would be made to the Clinical Commissioning Group's Executive and then on to the NHS Brent Board before a final decision was made.

10. **Clinical Commissioning Group update**

Ethie Kong confirmed that Rob Larkman had been appointed the Chief Executive of the North West London CCG, whilst Ethie Kong was to chair the Shadow CCG Board which also included two lay members including a lay vice chair. A timetable of public meetings would be advertised in local newspapers and the CCG would consist of five localities. Work was under way to develop the CCG constitution and the first draft had gone to GP practices for consultation. There would also be consultation with patient user groups and the CCG was working with Brent LINk to ensure that they had the relevant contact details. Ethie Kong confirmed that the CCG had been delegated its budget as of April 2012.

Councillor Leaman enquired whether details of a who's who could be provided of the CCG and how many public meetings were scheduled to take place. Councillor Daly stressed the need for the committee to see the relevant reports so that it could undertake proper scrutiny.

The Chair confirmed that the committee would like to receive progress reports in future and also a report on the CCG meeting that had happened on 30 May. In response to comments from Brent LINk representatives, she also requested that information be made more transparent in future.

Ethie Kong confirmed that two public meetings of the CCG were presently scheduled

Andrew Davies commented that verbal updates had been provided up to now as it was felt that this was the most appropriate way of informing Members, however reports would be provided in future.

11. **Health and Wellbeing Board update**

Andrew Davies updated Members regarding Health and Wellbeing Board (HWB) developments, reporting that the Shadow HWB May meeting had discussed the direction of travel with regard to the public health transfer. In respect of the Joint

Strategic Needs Assessment that was feeding into the HWB strategy, working groups had been created to cover a range of areas following feedback received from the consultation. Consultation on the HWB strategy would take place over the summer of 2012. Andrew Davies advised that he would provide reports at future meetings for this item.

12. **Health Partnerships Overview and Scrutiny Committee work programme**

Members noted the suggested work programme for 2012-13.

13. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled for Wednesday, 18 July 2012 at 7.00 pm. Andrew Davies advised that a pre-meeting would take place at 6.15 pm.

14. **Any other urgent business**

None.

The meeting closed at 9.55 pm

S KABIR
Chair

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	Health Partnerships Overview and Scrutiny Committee 18th July 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Brent Improving Access to Psychological Therapies Service

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee has been keen to carry out more scrutiny of mental health services in Brent. Clearly this is an important area, but one that has been overlooked by the committee in recent years as it has focussed attention elsewhere. In order to introduce councillors to mental health provision in Brent, a presentation will be given at the committee on Brent's Improving Access to Psychological Therapies Service (IAPT).

1.2 IAPT is one of the key mental health interventions available in Brent and has been in place since December 2010. In that time there have been 6,350 referrals to the service. It works with people who meet the following criteria:

- Clients with mild to moderate anxiety and or depressive disorders
- Those who can be managed within a primary care setting
- Clients able to benefit from short term psychological interventions.
- People who do not have complex needs or risk issues or social problems as the main focus.

1.3 A presentation pack has been published with the committee's agenda. The presentation will be delivered at the committee's meeting by the IAPT joint Clinical Lead, Dr Anupama Rammohan and Dr Cherry Armstrong, a GP commissioning lead and member of the IAPT Performance Board. When members asked for a report on IAPT the following information was requested:

- How the scheme is functioning
- The referral process
- Average waiting times for treatment from the point of referral
- GP attitudes towards the scheme

1.4 Members should ensure their requests for information in relation to these areas are met by the presentation and subsequent questioning.

2.0 Recommendations

(i). The Health Partnerships Overview and Scrutiny Committee should consider the presentation on IAPT services and question Dr Anupama Rammohan and Dr Cherry Armstrong on the schemes operation in Brent.

(ii). Members should consider how they want to follow up their interest in mental health services during the remainder of 2012/13, so that additional items can be added to the committee's work programme.

Contact Officers

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	Health Partnerships Overview and Scrutiny Committee 18th July 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Care UK Serious Incident

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee have requested a report from NHS Brent on the serious incident reported by Care UK at the Urgent Care Centre at Central Middlesex Hospital. Councillors will recall from their previous meeting the serious incident was recorded when Care UK become aware of a queue of 6000 patients who had not been discharged from their systems. Upon investigation it became clear that many of these patients had been sent for x-ray but it could not be confirmed that the radiology reports had been reviewed for missed pathology. In addition, discharge notifications had not have been issued to GPs for these patients. Clearly this presented a risk that patients were not properly diagnosed, or potential problems not picked up in a timely fashion.

1.2 A further report and action plan have been provided by NHS Brent into this issue, as a full investigation has been completed since the committee last met. The report focuses on safeguarding issues, but the action plan is deals more generally with system improvements that need to be made following the identification of the issue.

1.3 Representatives from Care UK and NHS Brent will be at the committee to present this report and answer questions in relation to this issue.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the report from NHS Brent on the serious incident at the Central Middlesex Hospital Urgent Care Centre and question representatives from the PCT and Care UK on the action they have taken since the identification of the issues connected to radiology.

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CARE UK (CUK) – SI

1. Background

On the 14/03/12 the local medical director (LMD) Care UK noticed that "sitting" on the IT system was 5978 radiology results that hadn't been electronically released by the referring Care UK GP and therefore discharge summaries had not been forwarded to the patients respective GP practices.

This report focuses primarily on the impact on children and the findings and actions in respect of safeguarding children. A full action plan arising out of the investigation is attached in Appendix A.

Of the 5978 results 1564 of them related to children.

1.1 A RAG (Red; Amber; Green) rating methodology was used to review the missed cases

1.12.2. RAG

Category	Description
Red	Confirmed fracture/ other pathology which may have altered the course of treatment given.
Amber	An abnormality identified but on review of patient consultation notes, appropriate care was provided.
Green	No fracture or abnormality identified and treated appropriately at time of consultation.

2. Timeline of events

- 14/03/12 – CUK personnel noticed 5978 radiology reports "sitting on " the IT system waiting to be released
- 30/03/12 - CUK advised NHS Brent officers about these 5978 cases
- 04/04/12 – SI logged on STEIS by CUK
- 05/04/12 - A joint letter (NHS Brent and CUK) was sent to all NHS Brent GP Practices informing them about the SI and how this was going to be managed in terms of the impact on their patients; a RAG rating system was agreed with a clear plan of how to manage patient from each group
- 18/04/12 – First meeting of the SI review panel, and every week thereafter
- 06/06/12 – Final report and action plan sent to NHS London by CUK
- 13/03/12 – "Mop up" meeting to confirm agreed actions and timelines in relation to monitoring of the action plan

3. Key actions taken

3.1 Setting up of the SI panel - ToR agreed

3.2 Ist meeting of the panel held on 18/04/12

3.3 During the SI Care UK provide weekly written updates to NHS Brent; updates included specifics in term of the Safeguarding issues relevant to the SI

3.4 Child Protection (CP) and Children in Need (CIN) - NHS Brent working with Designated Professionals (DP) to manage all children identified within the 5978 reviews, and to take appropriate action(s) as necessary

3.5 DP provided support to the SI panel

3.6 One of meeting held with key CUK personnel, DPs and senior NHS Brent officers to discuss, address, and agree safeguarding going forward.

4. CUK Safeguarding Review Process

A separate review of all child attendees from start of service on 28th March 2011 till March 14th 2012 who underwent an x-ray was reviewed and checked against the Child Protection Registers from the following Social Services Boroughs: Brent, Ealing and Hounslow boroughs.

4.1 Child Protection Plan List - CPPL

Brent Urgent Care Centre (UCC) at The Central Middlesex Hospital (CMH) receives CPPLs from the following Social Services Departments:

- Brent
- Ealing
- Hounslow

The review and final report from CUK established that the agreed Child Protection Policy (Safeguarding Children – Brent Urgent Care Centre (April 2011) was not adhered to by the service provider.

A number of issues were identified as part of the SI investigation in particular

- The identification, logging, and onward referral processes required tighter and more robust management and auditing by Care UK.

4.1.1 Identifying CPPL patients included in the review (including out of area)

CUK only has access to the three local lists (4.1); in order to identify patients identified as being in area and on any of the three lists identified above CUK built a temporary electronic database. This temporary database was developed from entering information from the three 13th April 2012 CPPLs enabling an effective way of cross-matching the lists of patients from this date (only), because CUK was instructed by Brent LA not to retain CPPL lists, therefore, cross matching could only be based on this list.

Because CUK is aware that the CPPLs frequently changes, the identified children were matched against the list in force (13/04/12) rather than the list in force at the time of the child's initial presentation.

4.2 Number of children who attended Brent UCC CMH

Within the overall cohort of 5,978 **attendances**, children (under the age of 18) accounted for 1564 of this total. All of these attendances were reviewed and graded (see section 1.2.2).

4.3 Review process – CPPL

A process was put in place for the 1564 x-ray reports to be clinically reviewed by a competent team of radiographers and doctors. The cases were then categorised using the RAG rating.

4.3.1 RAG rated actions

Children identified as "red" patients'; parent/guardian/carers were written to requesting that they contact Care UK to arrange a telephone appointment.

"Amber" rated children's parent/guardian/carers were written to inviting them to contact Care UK if required.
"Green" rated children – no contact was made with the parent/guardian/carers

4.3.2 Outcome of the Review process

In response to the 1,564 attendances and review, two areas were identified as follows:

	Red	Amber	Green
Number of **children** with frequent attendances (more than 6 times a year	0	0	0
Number of **children** x-rayed more than once in year (based upon their highest RAG grading)	7	9	68

It should be noted that the children who attended on a number of occasions, was graded to the highest category, therefore a child with two attendances one of green and one red; was shown in the red category.

4.3.3 From this reporting, CUK confirmed the following patients attended the Brent CMH UCC:

	Brent CPPL	Out of Area (Ealing CPPL)
Exact Match - Name and date of birth matched	2	2
Near Match - date of birth mis match	0	1
Patient who attended more than once	0	0
"Fuzzy Search" - Name but no date of birth on Non LAC Legal Status List.	1	0

4.3.4 Brent CPPL patients

As shown above, Brent CPPL matched two patients with an "exact match" and one patient through a "fuzzy search" as this child was entered on the "Non LAC Legal Status List" where date of birth is not recorded, therefore, an exact match couldn't be made, the search indicated that they may be on the list; on further investigation it was found that Brent LA had no record of this child, therefore, CUK have not been able to onward refer this patient to the LA.

4.4 Immediate actions taken

CUK took immediate action on 1st April 2012, implementing Safeguarding Alert Features on the IT system e.g. specific reference to high levels of attendance (more than three) has been included as part of CUK's local Safeguarding Children – Brent Urgent Care Centre April 2012 policy. This is being underpinned by an appropriate protocol which is being developed as part of the CUK's Brent UCC CMH action plan.

4.4.1 Identifying patients at point of presentation

CUK receptionists must check all children at the time of presenting in accordance with the Safeguarding Children – Brent Urgent Care Centre CMH April 2011; and with effect from January 2012, CUK processes were made more robust regarding the identification of patients at the point of presentation.

4.4.1.1 The receptionist manually checks all the CPPL; to confirm this action has taken place a note of "CPPL list checked" is entered within a generic field on the clinical IT system; where a note is not entered on an appropriate patient's record, it will be assumed that the check was not performed in accordance with the agreed procedure. Prior to this process being implemented CUK was not able to confirm that the CPPL check was performed at all prospective attendances e.g. when the child/young person **first presented** during he SI period of 28/03/11 to 28/03/12.

4.4.2 On the 17th May 2012, the requirement for checking the CPPL registers were further reinforced e.g. the importance of consistent checking in a discreet but effective manner.

4.4.3 CUK is creating an electronic solution that will enable the receptionist to check the CPPL register through the use of automated rather than manual search.

4.4.4 CUK is also investigating the potential to import data from the CPPL and Attendance Lists from the clinical system to enable systematic CPPL audits to be carried out to ensure that at risk patients have been appropriately identified.

A "CPPL Flag" will be used rather than a generic entry; to enable improved monitoring both from an identification and onward referral monitoring perspective.

It is expected that these actions ensures the systematic identification of the relevant children at the point of presentation; this is being bolstered by regular and appropriate auditing to ensure any issues of non compliance are identified, appropriately managed and resolved.

5. Conclusion

The CUK SI highlighted:

- Concerns about the robustness of CUK's safeguarding procedures
- Concerns about staff's understanding and implementation of the safeguarding process and procedures
- The need to undertake regular audits to validate staffs compliance with their duty of care in terms of safeguarding.

5.1 Post SI investigation

Following the end of the SI and the output associated with this, NHS Brent is confident that the provider has improved its management and operations in relation to safeguarding.

The actions contained in the (attached) plan, plus the monitoring of this by NHS Brent officers, will further serve to provide assurance to the Trust that

CUK is working and adhering to the agreed safeguarding policy and procedures.

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Brent Urgent Care Centre Action Plan (from the Root Cause Analysis Investigation report June 12)

NO:	Recommendation	Actions	By Whom	Comments	Completion date
1	Review the recruitment processes.	A full review the recruitment processes of Senior Operational Staff and Senior Clinical Staff to be undertaken including: • A review of the recruitment assessment procedures: • Competency assessments.	Care UK Health Care UK HR & Operational Directors.	Post review, any amended policies to be shared with the commissioners.	**31.08.12**
2	Robust training of the radiology process at Brent UCC from first contact to discharge for all staff including the Brent UCC management team.	The IT Business System Clinical Team to undertake training of all staff at Brent UCC including the management team.	IT Business System Clinical Team.	Training completed, end to end process	**31.08.12**
3	Robust induction programme which includes the radiology process for all Locum/Agency staff.	Brent UCC Service Manager and the IT Business System Clinical Team trainer to devise a "radiology guide" for locum/agency staff.	Brent UCC Service Manger & IT Business System Team Clinical Trainer	Regular agency staff to have access to on line training modules and induction training of local processes including the radiology process.	**13.07.12**

NO:	Recommendation	Actions	By Whom	Comments	Completion date
4	An operational process to ensure the radiology reports are reviewed by a competent clinician on a daily basis and scanned in a timely fashion.	Brent UCC Service Manager and Brent UCC Local Medical Director to devise an operational process to identify a competent clinician to review the radiology reports on a daily basis. An operational process to be devised to ensure all radiology reports are scanned into the patient's notes and then ticked off as complete on the IT patients system.	Brent UCC Service Manager & Local Medical Director	Interim solution in place, a Shift Leader is appointed and is responsible for the management of the radiology list. A Shift Leader role description and is being devised and will be shared with commissioners at the next JSR meeting.	06.07.12 27.07.12
5	To devise a detailed operational "daily/weekly/monthly procedures resource file". (Standard Operating Procedures – SOP).	Brent UCC Service Manager and Deputy Manager to devise an operational detailed operational "daily/weekly/monthly procedures resource file" (SOP) For when new managers take over they are aware of all the daily operational procedures and are then able to monitor if staff are performing the necessary tasks.	Brent UCC Service Manager & Deputy Manager	A truncated version of SOP's to be available for agency/locum staff including the patent pathways and referral details.	06.07.12

6	Newly mobilised services to have "post go live IT test/audits" at regular intervals i.e. monthly for the first three months and then bi monthly for next six months and then quarterly test/audits.	The IT Business systems team need to devise a "post go live" audit template. The audit should include the checking of the radiology queues and the discharge fax queues to ensure the processes are working correctly post go live of service.	IT Business System Team with Mobilisation Team	Review of mobilisation process to build in specific 'tests runs' for specific service streams eg Radiology process in UCC's. Review meeting planned 17/07/12.	31.08.12
7	Datix DIFF Two training mandatory training for all Service Managers and their deputies to attend.	Brent UCC Service Manager, Deputy Manager and Local Medical Director to attend the Datix DIFF two training.	Brent UCC Service Manager & Deputy Manager & Local Medical Director	Local training to be completed by the Governance team.	31.08.12
8	To reduce the service dependency on locum staff.	Review/revise posts and employment packages to encourage recruitment to permanent posts.	Brent UCC Service Manager & Deputy Manager & Local Medical Director & Regional HR Manager	Care UK working towards using regular agency staff. A remuneration review is underway to attract and retain staff. Evidence of progress to be reviewed at JSRs by staff category (substantive, regular agency, ad hoc agency percentages) .	27.07.12

9	Senior Management at Brent UCC needs to take ownership for their service's governance objectives.	Senior Management at Brent UCC, to evidence on a monthly basis to their Divisional Clinical Governance Manager evidence of Clinical Governance meetings and updates on Governance action plans.	Brent UCC Service Manager & Deputy Manager & Regional Clinical Governance Manager	Site Governance meetings to be held minimum of bi monthly. To be well attended, minutes taken and actions brought forward and closed when completed. Evidence – minutes/actions plans to be submitted as part of the internal monthly reporting.	27.07.12
10	IRMER update training for all clinical staff referring to radiology.	All Clinical staff who are referring for radiology diagnostic tests need to have regular training updates.	Brent (UCC) Local Medical Director and Lead Nurse. Care UK Healthcare Division Diagnostic Manager	Training/update to be delivered to employed staff. List of trained staff to be submitted. Evidence – appropriate certificates to be kept on staff files. IRMER training to be in line with legislation Nurse Practitioner agency checklist to be amended to ensure agency NPs provide evidence of IRMER training.	31.08.12

Brent Urgent Care Centre Action Plan relating to Safeguarding Children (from the Root Cause Analysis Investigation report June 12).

NO:	Recommendation	Actions	By Whom	Comments	Completion date
12	Robust induction programme which includes the radiology process and the safeguarding referral pathways for all staff including Locum/Agency staff.	Brent UCC Service Manager and Brent UCC Safeguarding Lead to devise a "safeguarding referral guide" .	Brent UCC Service Manger & Safeguarding Lead	Requirement for locum induction/reference pack	**06.07.12**
13	To ensure reception staff to check and log all child attendances as per procedure in the local Brent UCC safeguarding Children policy.	Brent UCC Service Manager and Brent UCC Safeguarding Lead to ensure the process of checking the Child Protection Plan Lists (CPPL) by reception staff are carried out. To be audited on a monthly basis	Brent UCC Service Manger & Safeguarding Lead	Audit to be submitted as part of the internal monthly reporting to Care UK Divisional Safeguarding Lead.	**05.07.12**
14	Change "(CPPL Check" to a mandatory field on the registration screen and for a pop up box to appear.	The registration field in Adastra needs to flag up and ask the question have you checked the CPP List for each DOB entered under 18 years of age. The Head of IT to raise a change request with Adastra (03/05/12)	Brent UCC Service Manger & Safeguarding Lead & Head of IT	Brent UCC Safeguarding Lead to ensure this has been implemented.	**29.07.12**
15	Ensure that all Locums are provided with the appropriate safeguarding children policies & referral procedures.	Brent UCC Service Manager and Brent UCC Safeguarding Lead to devise a "safeguarding referral guide" for locum/agency staff.	Brent UCC Service Manger & Safeguarding Lead		**13.07.12**

16	Ensure all employed staff undertake required Safeguarding training at the appropriate level.	All doctors and nurse practitioners Level three – Health Care Assistants Level 2, Admin Level 1.	Brent UCC Service Manger & Safeguarding Lead	Staff training data to be entered onto the Mandatory training collator on Harvest. To be reviewed on a monthly basis as part of the monthly internal reporting and CQC compliance.	**27.07.12**

	Health Partnerships Overview and Scrutiny Committee 18th July 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

North West London Hospitals NHS Trust and Ealing Hospital NHS Trust merger – Full Business Case

1.0 Summary

1.1 Members of the Health Partnerships Overview and Scrutiny Committee will be familiar with the plans of North West London Hospitals NHS Trust and Ealing Hospital NHS Trust to merge. Work on this has progressed to the point where a Full Business Case for the merger has been completed and submitted to NHS London – they considered it at their board meeting on the 28th June. Both trust boards have approved the FBC final draft in principle.

1.2 The overall conclusions of the final draft FBC have not substantially changed from the version prepared earlier this year, but that needed additional work before it could be submitted for approval. It is recommending that the two trusts should merge and that by 2015/16 the merged trust could deliver a 1% surplus of £6.3m, putting it in a position to apply for Foundation Trust status.

1.3 It is noted in the report provided by the hospital trusts that the merger is conditional upon:

- The full realisation of merger synergies (clinical and financial)
- The incorporation of robust management processes, with full clinical engagement at NWLHT and EHT to provide confidence in the delivery of the challenging Cost Improvement Programmes (CIPs) requirement for the new organisation
- Securing £96.5m additional funding from NHS Commissioners and Department of Health (DH), to underpin the transformation and transition to 2015/16.
- The continued support of NHS North West London (NHS NWL) and Clinical Commissioning Groups (CCGs).

1.4 Assuming the various stages in the process can be successfully negotiated the merger will be completed in early 2013 at the earliest. Full details are set out in the report and appendices provided by the hospitals trusts. Dr William Lynn, Consultant

Physician at Ealing Hospital NHS Trust and David Cheesman, Director of Strategy at North West London Hospitals NHS Trust will attend the committee to introduce this report.

2.0 Recommendations

2.1 Members are recommended to consider the reports provided by North West London Hospitals NHS Trust and Ealing Hospital NHS Trust and question officers on the merger process and Full Business Case.

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Friday 6 July 2012

Update on the proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust for Brent Health Partnership Overview and Scrutiny Committee meeting on 18 July 2012

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1. Introduction

This report provides an update for the panel on the proposed merger of Ealing Hospital NHS Trust (EHT) and The North West London Hospitals NHS Trust (NWLHT) and the development of the Full Business Case (FBC).

This report is essentially the same paper which was provided to the Trusts' Boards on 19 and 20 June as part their considerations of the draft Full Business Case. A short briefing for stakeholders providing an overview of the draft FBC, the next steps and clinical benefits is attached (appendix 2).

Specifically this report provides information about:

- Final draft Full Business Case – it's content and on-going work to underpin the business case (an executive summary of FBC is attached – appendix 3)
- Internal and external processes
- Transactions agreement (to support the financial agreements for merger)
- Next steps including provisional timeline and processes
- Equalities Impact Assessment
- Communications and engagement

Since the Trust Boards met on 19 and 20 June, NHS London's Board has considered the draft FBC on 28 June as planned and provided their support for the final draft of the business case and the proposed timeline (see paragraph 7).

The draft FBC makes the case for the organisational merger of the two Trusts without any major service change. Decisions about how services will be provided across north west London in the future are subject to a public consultation as part of the Shaping a healthier future programme which is being led by NHS North West London.

2. Background

The Outline Business Case (OBC) for the proposed merger was approved by the Trust Boards and NHS London in October 2011. In December 2011 the merger

programme was strengthened and the nine project work-streams were formalised with Executive leads from one of the two Trusts.

Since then the programme has been working towards producing the FBC for Trust Boards and NHS London (NHSL) approval prior to its formal submission to the Department of Health's Transactions Board (DHTB). It is the DHTB, which has the authority to recommend approval to the Secretary of State for the dis-establishment of the two Trusts and establishment of the new organisation. DHTB will only do this when all issues are resolved. This includes clarity around funding.

The original FBC submitted to NHSL in March 2012 was not formally considered by the Trust Boards or NHSL because of concerns raised as part of the Due and Careful Enquiry (DCE) process undertaken by KPMG relating to the scale of merger savings/synergies and the level of detail to support cost improvement plans (CIPs) in particular at NWLHT.

As a result PwC were commissioned to support the Trusts; identify the total potential merger synergies/savings, identify and develop further CIP opportunities, update the LTFM and finance chapter to reflect these additional opportunities and the current year financial agreements with Commissioners.

A final draft FBC was completed on 6 June 2012 and submitted to NHS London. The Organisational Futures Programme Board (OFPB) and both Trust Boards have approved this final draft in principle. NHSL's Board are due to consider the final draft FBC on 28 June 2012 at their private meeting.

3. The final draft Full Business Case (FBC)

3.1 Summary

The overall conclusions of the final draft FBC have not substantially changed from the version prepared in March 2012. It remains clear that the two trusts are 'Stronger Together' and that by 2015/16 the merged Trust could deliver a 1% surplus of £6.3m, putting it in a position to apply for Foundation Trust status.

However, this broad conclusion is conditional upon:

- The full realisation of merger synergies (clinical and financial)
- The incorporation of robust management processes, with full clinical engagement at NWLHT and EHT to provide confidence in the delivery of the challenging Cost Improvement Programmes (CIPs) requirement for the new organisation
- Securing £96.5m additional funding from NHS Commissioners and Department of Health (DH), to underpin the transformation and transition to 2015/16.

Implicit in the above, but no less critical to success, is to sustain the momentum and engagement of key stakeholders, within both the Trusts and the continued support of NHS North West London (NHS NWL) and Clinical Commissioning Groups (CCGs).

3.2 Detailed changes in the final draft FBC

Following the Trust Boards' approval of the OBC, the FBC development has progressed to a final draft.

We have acknowledged and reflected the NHSL feedback (highlighted in their draft assurance report based on the March 2012 submission) and the findings of the KPMG Due and Careful Enquiry (DCE) report in refreshing this latest version of the FBC. For example, some refinements have been made to chapter 9 (governance) in line with feedback and includes a clearer Board sub-committee structure.

The final draft FBC has the following content updates from the OBC to bring to your attention:

- The clinical vision is aligned closely with the challenge set by the 2012 commissioning intentions received from NHS North West London.
- Clinical and patient benefits resulting from the merger are described with a phased approach detailing benefits within the first two years with more explicit examples of what will be different.
- Throughout the document reference is made to the proposed name of the new Trust which is **London North West Healthcare NHS Trust**.
- Performance information is refreshed in chapter 3 so that the Trusts' profile includes April 2012 data.
- Chapter 8 on finance and the supporting LTFM has been amended to reflect; 2012/13 agreed financial plans and income levels, the latest Monitor financial planning assumptions, the further work undertaken on merger savings and synergy opportunities and the further progress made detailing the CIP schemes to be delivered in 2012/13 and 2013/14.
- A new organisational vision is articulated based on a joint Executive Director Workshop hosted in February 2012 along with a new proposed organisational structure.
- A new chapter 11 has been added describing the planning and implementation plans and milestones to ensure a successful merger, which were subsequently scrutinised as part of the Due & Careful Enquiry led by KPMG.

4. On-going work to underpin and support the FBC

The final draft of the FBC now reflects the latest position in respect of the Commissioner plans for Shaping a Healthier Future (SaHF) in north west London, the true scale and potential of merger synergy and savings and the maximum scale of CIP and efficiency the merged trust can deliver in its base case for organisational

merger. We now have confidence that the scale of these savings plans is realistic and achievable based on appropriate benchmarking of services led by PwC and agreed with senior clinicians.

The benchmarking included; review of HRG costs by specialty, clinical quality and efficiency analysis (length of stay, day case and re-admission rates) as well as detailed workforce analysis (staff grade, cost, and productivity). This analysis has assisted the development of £72 million of CIPs. PiDs (Project Initiation Documents) have been produced that outline savings schemes to be delivered in 2012/13 and 2013/14. The PiDs provide the rationale for why the schemes are feasible, the high level actions required to deliver them, who is leading and the scale of saving to be delivered.

It is clear therefore, that the schemes and opportunities exist but given the short time scale to identify them, there is on-going work required to fully develop and strengthen these. At the same time, given the scale of the challenge, there is the need to further strengthen and resource the role of the Quality, Innovation, Productivity and Performance Programme Management Office (QIPP PMO) and overall clinical governance arrangements for signing off the schemes and then monitoring and holding to account the scheme owners for delivery. This further work and revised arrangements will take place and be implemented over the next eight weeks and should give confidence to the Boards that the financial assumptions and plans that underpin the FBC modelling assumptions can and will be delivered.

5. Assurance processes

A number of internal and external assurance processes have been instigated to ensure that the merger is delivered safely. The below provides an update on these.

5.1 Internal Trust-led assurance process

As part of the Trust-led assurance process the merger programme has commissioned three areas of due diligence:

- Due and Careful Enquiry (DCE)
- Legal Due Diligence (LDD)
- Clinical Due Diligence (CDD)

DCE: The Due and Careful Enquiry incorporates an independent detailed review of the FBC's financial modelling and assumptions, as well as a review of the state of readiness of all the implementation planning undertaken by the existing work-streams. KPMG were commissioned to undertake this work and completed a first review in March 2012 of the original FBC as described above.

KPMG fully commenced a refresh of the DCE process on the 6 June 2012 and at the time of writing aim to complete their review by 15 June. We are awaiting their final report.

LDD: Legal Due Diligence includes a detailed review of the legal agreements that underpin the merger transaction as well as ensuring appropriate legal title is held by the existing Trusts to their current asset base, that appropriate arrangements are in place for all trading and lease arrangements and that there is an up to date record of all potential legal liabilities faced by the Trusts.

The LDD has also been refreshed to support the Final Draft FBC and was submitted to NHSL on 29 May and to both Trust Boards. It is the initial assessment of both Trust CEOs that there are no significant issues identified which would prevent the merger progressing as planned, although there are a number of recommendations requiring action both before and after the merger which relate to leases and community property transfer etc. A copy of this report can be viewed on our website: http://www.nwlh.nhs.uk/stronger-together/documents/

CDD: The Clinical Due Diligence process has completed phase one, which was a review of hard data for both Trusts and this was submitted to NHS London on 9 March with a draft FBC and is now part of the NHSL assurance process.

The full CDD includes a further two phases with soft data collection, peer review and independent 'confirm and challenge' sessions culminating in the phase three handover report to the new Trust Board. This work is managed through the ninth work-stream which reports directly to the Merger Programme Operating Board (MPOB) with a clinical chair and under the leadership of the chief executive of EHT. Phase 2 is on track for completion at the end of July 2012 and the report will be considered by both Trusts and then used to inform the future governance arrangements of the new Trust which will be reflected in the Phase 3 handover report.

5.2 External NHSL assurance process

NHSL commenced a detailed assurance process in February 2012 which reviewed quality and safety, patient experience, governance, financial plans, integration planning and readiness in respect of key areas; IT, finance, HR/OD and estates. A draft report was produced and shared with the merger programme and the findings have been reflected in the final draft FBC for progression and development of integration plans as appropriate.

NHSL have formally recommenced the refresh of their assurance process, which has primarily focussed on the revised finance chapter, LTFM and the plans that underpin these. This process was due to complete on 15 June 2012. Given the current position in regard to the CIPs programme (described in 4.0 above) and definition of financial benefits through merger, the NHSL assurance process also remains incomplete and will only be finalised when all the outstanding work and processes are complete.

6. Transactions Agreement (TA)

As part of the FBC submission to NHSL and ultimately the DH Transactions Board a legal agreement in the form of a formal Transactions Agreement (TA) is required. The TA is signed by the Trusts and respective funders, and outlines the financial agreements incorporated to support the merger transaction. At the OBC stage this was referred to as the Heads of Terms.

The FBC concludes the merged Trust will need significant one-off support funding to implement the change, underwrite the early years trading deficits and improve its liquidity position in advance of an FT application. Included in these costs are the merger programme costs (2012/13 and 2013/14) of developing the FBC and preparing for and implementing the integration.

Overall the level of support totals £96.5m and to date there has been in principle agreement to fund £33m (the balance to be negotiated with Commissioners, NHSL and DH following approval of the FBC by the Trust Boards but prior to formal submission to the DH). The Transactions Agreement has been drafted and highlights the financial support required for a successful merger (£96.5m) as described above and will now need to be shared and negotiated with the NWL Cluster and NHS London.

7. Approval processes and timelines

Before the FBC can be considered at an NHS London Board meeting held in public it will need to be supported by the Board of NHS North West London who will be required to provide a letter of support for the FBC and agree their share of any financial commitments to the funding arrangements to support the merger. The programme has therefore been working closely with NHS colleagues in the commissioning team to ensure there is alignment of plans between the Cluster and the merger programme. The funding arrangements will also require the support of the NHS NWL Challenged Trust Board (CTB).

Given the short timescale to undertake the additional work, produce the final draft FBC and subject it to the rigours of both the DCE and NHSL assurance process, both Trusts Boards considered the final draft FBC on 19 and 20 June, in advance of it being considered by NHS North West London and NHS London Boards. As a consequence it is now recognised that given the requirement for the FBC to be considered at an NHS London public Board (only once the Transaction Agreement is finalised and any further assurance NHSL may require is addressed to support the FBC) and then gain DH Transactions Board approval, the existing proposal for 1st October 2012 merger referred to in the FBC will not be achieved. A revised provisional timeline for the approvals process to establish the merged Trust is as follows:

Final draft FBC

- NHS London Board (private session) - 28 June
- Department of Health Transactions Board - 26 July

Final Full Business Case

- Trust Boards (public session) - early September
- NHS North West London Board (public session) – early September
- SHA Board (public session) – September
- Department of Health Transactions Board - October

Merger completed early 2013 at the earliest

8. Co-operation and Competition (CCP) panel review

The role of the CCP in respect of potential mergers of organisations is to assess whether there are material costs to the public and patients as a result of restricting choice or competition. A final CCP panel meeting was held on 13 June 2012 and concluded:

"Overall, we concluded that the merger of Ealing Trust and North West London Trust is unlikely to give rise to a material cost for patients and taxpayers because there will remain sufficient patient choice and competition. We concluded therefore that the merger is consistent with Principle 10 of the Principles and Rules."

The final report from the CCP is now available on their website http://www.ccpanel.org.uk/cases/Merger_of_Ealing_Hospital_NHS_Trust_with_North_West_London_Hospitals_NHS_Trust.html

9. Equalities Impact Assessment of the FBC

In response to a request from the three local Overview and Scrutiny Committees (OSC) an Equalities Impact Assessment (EIA) of the FBC has been completed and was submitted to NHSL with the FBC on 29 May 2012.

Overall the assessment of the FBC was positive when reviewed chapter by chapter, with recommendations for the new Trust to ensure a strong and visible commitment to equalities is maintained. Some areas of negative impact were highlighted, mainly in response to the level of merger savings which need to be achieved and the potential impact on different staff groups. In addition, there were concerns about how the new organisation's governance arrangements might not be as strong as the existing ones in recognising Equality and Diversity in the senior committee governance structures and this will now be reviewed.

A copy of the Equalities Impact Assessment and cover letter as submitted to NHS London on 29.05.12 is attached as Appendix 1.

10. Communications and Engagement

Chapter 10 of the final draft FBC highlights the engagement undertaken with stakeholders since April 2011 and formal consultation with Local Involvement Networks (LINks) as required by the NHS Act (section 25). It highlights the key themes and issues raised by stakeholders, the Trusts' response to them, and includes formal letters giving views on the merger from LINks, Overview and Scrutiny Committees, Councils and other organisations.

In support of the publication of the FBC both Trusts will be continuing to engage and communicate with key stakeholders, including staff, regarding the Full Business Case, the next steps in the merger approvals process and also as the Trusts prepare for day one and beyond.

A series of open events have been arranged for staff to hear about and discuss the draft FBC with senior leadership from the two Trusts. A detailed staff engagement programme is now being developed to ensure staff continue to be fully involved as the Trusts begin to implement their plans for integration. Staff have also been provided with a short briefing explaining the FBC and the next steps.

Letters were issued to key stakeholders to advise them of the Trust Board meetings which are held in public and stakeholders are still able to email their views to the merger@nhs.net email address or contact the merger programme office if they would like someone to attend one of their meetings.

The Full Business Case (which includes an executive summary) has been placed on the Trusts and dedicated merger website www.nwlh.nhs.uk/stronger-together and the Trusts will also continue to attend this committee to discuss the FBC and explain the plans for integration. A stakeholder briefing paper is also available on the Trusts' websites and is attached (appendix 2).

11. Conclusions

The final draft FBC demonstrates that the two trusts are 'Stronger Together' with clear benefits for patients and staff and that by 2015/16 the merged Trust would deliver a 1% surplus of £6.3m putting it in a position to apply for Foundation Trust status.

Following the review of the final draft FBC by NHS London on 28 June the aim will be to progress with the establishment of shadow management arrangements at the earliest opportunity to maintain momentum on integration planning and to start to realise the benefits of the merger.

Simon Crawford, Senior Responsible Officer

APPENDICES:

Appendix 1: Equalities Impact Assessment and cover letter as submitted to NHS London on 29.05.12


E & D Form.doc


Assessing the Impact of the Merger FBC on

Appendix 2: Stakeholder briefing (see attached file).


fbc stakeholder briefing final version.

Appendix 3: Executive summary from final draft FBC (see attached file)


final draft fbc executive summary ju

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Assessing the impact of the merger full business case on equality and diversity

The attached document is an initial assessment of the impact of the full business case for the merger of the North West London and Ealing NHS Hospital Trusts (FBC) on equality and diversity. It follows on from the equality analysis undertaken as part of the outline business case published in 2011.

This initial impact assessment is part of the process for meeting the public sector general equality duty as outlined in Section 149 of the Equality Act, 2010; this Act brought together all previous equality legislation in England, Scotland and Wales, replacing the separate duties relating to race, disability and gender equality. The equality duty came into force on 5 April 2011.

Public authorities are required to have due regard to the aims of the general equality duty when making decisions and when setting policies. Understanding the effect of policies and practices on people with different protected characteristics is an important part of complying with the general equality duty.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it

The Equality Act, 2010 explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

It states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups.

There is no prescribed methodology for assessing the impact on equality on decisions such as that to merge two large public sector organisations (this being one of the changes brought about by the Equality Act) but a consistent methodology and proportionate approach have been applied in developing this document based on the

Equality Impact Assessment Form currently used by North West London Hospitals Trust. However, the principles of our approach are consistent with the previous requirement to produce an Equality Impact Assessment to a prescribed format.

The attached document assesses the effect of the merger by considering its impact (whether negative, positive or neutral) according to each of the substantive chapters of the FBC. It identifies gaps in the analysis and proposes a number of actions which will be taken forward as an integral part of the merger approval and implementation process. In particular, the revised FBC financial model was not available when this impact assessment was undertaken and its implications for equality and diversity of the workforce may need to be further considered.

In addition to the action plan, the main recommendations are as follows:

- As work progresses on the various work streams all areas should have an initial analysis of relevance to the Equality Duty carried out and recorded
- For those areas with greater relevance detailed action plans should be drawn up and reported upon as part of the PMO reporting systems
- Work should start immediately to prepare for the publishing of Equality Objectives on the day the Trust is legally constituted
- Workforce diversity data should be collected in order for the new organisation to have a baseline for any restructuring that may take place
- Workforce plans should include details of how the workforce can be reflective of the communities served by the new Trust
- The new organisation should have a plan in place to tackle under representation of staff groups with regards to protected characteristics when it comes to middle and senior management

The impact assessment will be continually updated as actions are completed and recommendations implemented.

The impact assessment will be subject to approval by both existing boards alongside the FBC. It will also be used to engage further with appropriate stakeholders such as BME staff networks and relevant local community groups.

Andrew Vickers
Programme Manager
HR/OD Workstream

Sajjad Iqbal
Assistant Director of Engagement and Equality
NWLH

29th May 2012

Ealing Hospital NHS Trust – Integrated Care Organisation & North West London Hospitals NHS Trust

Equality Impact Assessments Form: A record of the assessment

Function/ policy being assessed:

The proposed merger of Ealing Hospital NHS Trust and the North West London Hospitals NHS Trust – Full Business Case

Directory/service/corporate function/policy/strategy/scheme/business case

Full Business Case

Date of assessment:

02/04/12 – 27/04/12

Contact person for the assessment:

Sajjad Iqbal AD Engagement & Equality – NWLH NHS Trust

Members of the assessment group:

Sajjad Iqbal AD Engagement & Equality NWLH NHS Trust
Paul Stanton HR Director Ealing Hospital NHS Trust – Integrated Care Organisation
Don Fairley HR Director NWLH NHS Trust
Sajid Hussain Director Consult Enthuse Improve
Linda McLean Independent Consultant
D Williams HR BP NWLH NHS Trust
Meave Darroux Operations Director Brilliant Women
Maria Pervaiz University of Leeds

1 Aims of the function/ policy/document

To present a full business case for the merger of Ealing Hospital NHS Trust – Integrated Care Organisation (EHT-ICO) and the North West London Hospitals NHS Trust (NWLHT)

2 Current achievements and fact finding

Sources of information used, with references, location or links.
Anything you have learnt from previous consultation results with references or links. In particular any evidence you may have that impacts upon: **age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and human rights**

NWL Integrated Strategic Plan 2010

This document provides information on health needs across North West London including:

Population size
Age structure
lifestyle related diseases

This information is used to assist in clarifying the health needs of groups that fall within protected characteristics in Brent, Ealing and Harrow.

2010 Borough Health Profiles Department of Health

This document shows that the cultural diversity and high levels of immigration across Brent, Ealing and Harrow lead to specific common challenges. These include:

High levels of infectious diseases
Higher rates of illiteracy
Language difficulties

This information has been used to inform the EQIA process.

Equality and Human Rights Commission - Meeting the equality duty in policy and decision making

http://www.equalityhumanrights.com/advice-and-guidance/public-sector-equality-duty/news-and-updates-on-the-equality-duty/

This document provides valuable guidance on how to ensure equality considerations are embedded into decision making processes and has informed the EQIA process.

The public sector equality duty (the equality duty) is made up of a general equality duty which is supported by specific duties. The 'public sector equality duty' is the formal title of the legislation, the 'general equality duty' is the overarching requirement or substance of the duty, and the 'specific duties' are intended to help performance on the general equality duty.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

These are often referred to as the three aims of the general equality duty. The functions of a public authority include all of their powers and duties. This means everything that they are required to do as well as everything that they are allowed to do. Examples of this include: policy decisions, budgetary decisions, public appointments, service provision, statutory discretion, individual decisions, employing staff and procurement of goods or services and in the instance of the NWLH NHS Trust and Ealing ICO the document entitled:

Stronger together
The proposed merger of Ealing Hospital NHS Trust and the North West London Hospitals NHS Trust - Full Business Case

The Equality Act explains that having due regard for advancing equality involves:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encouraging people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

It states that meeting different needs involves taking steps to take account of disabled people's disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups.

The general equality duty and policy and decision-making

Both Ealing ICO and NWLH NHS Trust are required to have due regard to the aims of the general equality duty when making decisions and when setting policies. Understanding the effect of policies and practices on people with different protected characteristics is an important part of complying with the general equality duty. This can help both organisations to consider whether the policy will be effective for all sorts of different people. For example, does a particular policy meet the needs of people with protected characteristics? Does it minimise disadvantages faced by them? It can help to identify any negative impacts or potential unlawful discrimination, as well as any positive opportunities to advance equality. Identifying these areas may help both Trust's to develop practical courses of action to mitigate negative consequences or to promote positive ones.

Having due regard to the aims of the general equality duty is about using good equality information and analysis, at the right time, as part and parcel of decision-making processes.

Giving due regard to the relevance and proportionality of strategies, policies, functions and services assists the Trust to consider equality, diversity, and human rights. It also helps decide if an impact assessment is required and prioritizing these.

Due regard comprise two linked elements: relevance and proportionality**.**

Relevance may be identified using the following factors:

- The extent to which a service is or is not used by particular groups of people.
- Whether the strategy/policy relates to functions that previous consultation has identified as important
- If different groups have different needs or experiences in the area the policy relates to

Proportionality ensures that we can focus our effort and use our resources most effectively. There is little to be gained by carrying out an impact assessment of strategies, policies, services, and functions which are clearly not relevant. However, if an important strategy, policy, service or function is left out because relevance has not been identified; the proposal to merge is left vulnerable to legal challenge and implementing poor decisions.

Those areas with greater relevance will include, for example: changes to service delivery (including withdrawal of service), recruitment or pay policies and policies that set quality standards for others to follow. These should always be impact assessed.

Those with less or no relevance will include the internal systems, for example for processing travel expenses. It is likely that looking at such policies, services and functions to decide if they are relevant for equality, diversity, human rights and integration will be sufficient to show that due regard has been taken.

The weight that is given to equality, diversity, and human rights should be proportionate to its relevance to a particular strategy, policy, service or function. The greater the relevance of a strategy, policy, service or function to equality, diversity, cohesion and integration the greater regard that should be paid. This is the approach that has been taken with chapters and specific elements of the Full Business Case (FBC)

This assessment is crucial to enabling due regard. It will assist to fully understand the relevance and effect of the FBC and help in identifying the most proportionate and effective responses.

Table one identifies each chapter in the FBC, whether any of that chapter content is relevant to the equality , diversity and human rights (EDHR) agenda, and whether the likely impact on EDHR is likely to be negative, positive or neutral. It is possible to have all three impacts, and the equality impact recommendations then aim to accentuate the positive and mitigate, as far as possible, the likelihood of negative impacts emerging.

TABLE 1

Chapter	Component of the Full Business Case (FBC) being assessed	Is this Component relevant to the equality agenda? Yes / No	Initial assessment of potential impact (Positive, negative or Neutral)
3	**Profile of the trusts**	Yes	Neutral
4	**Commissioning Strategy In North West London**	Yes	Neutral
5	**The Case For Merger**	Yes	Positive
6	**Clinical Vision For The New Organisation**	Yes	Positive
7	**Clinical Benefits For The Merger**	Yes	Negative and Positve
8	**Financial Evaluation**	Yes	Negative and Positive
9	**The New Organisations Structure And Governance Arrangements**	Yes	Negative
10	**Engagement And Involvement Of Stakeholders**	Yes	Positive
11	**Integration And Implementation Plan**	Yes	Positive and Negative

This section of the paper takes each of the FBC chapters where we have identified relevance to the EDHR agenda, and for each of these chapters sets out the key relevant EDHR components of that chapter, gaps that have been identified in that chapter in respect of the equality component, and recommendations as to how best to address these gaps.

Chapter 3 Profile of Trusts

Key issues covered in this chapter of relevance to EDHR

Significant, long standing health inequality in North West London Cluster
Diverse needs of local community
Diversity of North West London
Poor patient experience survey results
Breaches against national standard for mixed sex accommodation

This chapter sets out background information to the two Trusts and as such is **considered neutral** with regards to impact on equality

Chapter 4 Commissioning strategy in North West London

Key issues covered in this chapter of relevance to EDHR

- Demographic factors and changes to the population served
- Epidemiology and changes in patterns of disease
- Changes in clinical practice
- Workforce factors, including education and training

Positive impact

The FBC makes as part of its case for change To improve experience mention of:

"the high levels of cultural diversity and immigration leading to specific common challenges common across all three Boroughs - high levels of infectious diseases, higher rates of illiteracy, and language difficulties which can make it hard for people who access services" (pg 42-43)

and of the desire to enable old people to live more independently (pg56). This clearly links into the legislative requirements to:

- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.

Gaps

Although ethnicity and age are touched upon briefly, information on other protected characteristics as service users could have strengthened the case for change as links could have been made with the increasing prevalence of lifestyle-related diseases such as heart disease and diabetes with gender, disability etc.

This chapter deals with the commissioning strategy and intentions as decided by the NW London Commissioners. As such although the questions to be asked relate to the potential

impact of the strategy and intentions on the FBC. **The potential impact on equality is assessed as neutral.**

Chapter 5 Case for Merger

Key issues covered in this chapter of relevance to EDHR

- The merger will bring together complementary services across a range of acute and community provision. Greater critical mass will allow the new Trust to meet the quality standards for acute care.
- The potential for integrated services across acute and community services will leave the new Trust ideally placed to support the move of care from hospital to community-based services

Positive Impact

The new Trust vision clearly implies that **all service users** regardless of protected characteristics are of equal importance. This is through the use of the phrase 'best quality healthcare'

"We will provide the best quality healthcare in the best place: home, community or hospital, by being responsive innovative and ambitious"

The new Trust promise to patients is clearly articulated on the principles of human rights e.g.

To treat you with dignity and respect

To show compassion by finding the time to listen and talk and do the small things that matter so much to you

The new Trust set of expectations which describe how the new organisations will be experienced by patients, staff and stakeholders are clearly based upon the principles of equality and human rights. (Pg 73, Table 8)

The potential impact on equality is assessed as positive

Chapter 6 Clinical vision for the new organisation

Key issues covered in this chapter of relevance to EDHR

- How the new Trust will improve the patients, carers and families' experience;
- How the merger will improve medical and nursing education and training;

Positive Impact

The shared service vision is built upon principles of equality and human rights

"A high quality patient, carer and staff experience with-

Personalised care
Strong culture of patient safety and minimising harm
Excellent patient information
No unnecessary waiting times Effective and timely decision making
High quality training and development
Culture of innovation and research

We will have high levels of patient satisfaction and experience" (pg90)

There is some use of equality data alongside clinical data to articulate the need for change. This is particularly useful when discussing the Inner NWL Integrated Care Pathway focussing on elderly care and diabetes.

There is a clear link to equality legislation when discussing the desire to achieve high rates of staff satisfaction:

- Become the employer of choice
- Achieve high rates of satisfaction and attainment from medical, nursing and other trainees/students being trained within the Trust
- Increased opportunities for multidisciplinary learning in a wider care setting centred around patient pathways
- Increasing contribution to research and innovation in the NHS (pg95)
- Provide the highest quality of care to a diverse local population (pg97)

and similarly when referring to staff access to education and training:

- Assure equitable provision of learning opportunities are available within the merged organisation
- Meet the education and training needs of a diverse and increasingly complex workforce, with new structures, roles and new ways of working (pg107)

Gaps

Evidence of robust baseline equality data for catchment area for new organisation

Evidence of corporate 'Knowledge' of communities in the catchment area for new organisation

Evidence of current (in)equity of access across all protected characteristics

Evidence of effective measures to address low levels of staff satisfaction

Recommendations

Collate robust baseline data of local communities for the new Trust based upon protected characteristics to be ready for when new Trust becomes a legal entity

Collate database of local organisations that represent different protected characteristics within the catchment area served by new Trust

Although there are some gaps in the information used to present the clinical vision for the new organisation the potential impact on equality is assessed as positive.

Chapter 7 Clinical and patient benefits of the merger

Key issues covered in this chapter of relevance to EDHR

- The merger will bring direct benefits to patients with improved clinical outcomes, better patient experience, more equitable access to specialist care and improved access to care closer to home.

Positive Impact

The FBC recognises that in delivering the change there will have to be imput from staff and service users as such the following actions have been taken:

The Communications & Engagement Plan sets out how the Trust will consult and engage with multiple stakeholders regarding the future changes.

Organisational Development and Human Resources Strategies describe the mechanisms and support that will be used to manage change and support our staff in the merged organisation. The Organisational Development Strategy also identifies the need to develop a comprehensive training and development programme to ensure the right staff and skills are in place and it describes the initiatives and interventions that will be utilised to achieve this. (pg122)

Gaps

This chapter is concerned with the clinical and patient benefits of the merger and also how support delivering this change however it fails to take into account:

Evidence of EDHR as a business critical function to deliver the change

Clear articulation of the mechanism for embedding Human rights, Equality & Diversity into Clinical delivery

Evidence of supporting ICT information Systems to enable and support the implementation of statutory and non-statutory equality duties.

Recommendations

EDHR team to work with clinical divisions and local communities from outset to help set up corporate and directorate equality objectives for new Trust.

New ICT systems including intranet to have equality analysis carried out in order to ensure that systems are accessible.

Due to equality diversity and human rights not being listed within delivering the change sections the potential impact on equality is assessed as negative and positive.

Chapter 8 Financial evaluation / LTFM

Key issues covered in this chapter of relevance to EDHR

- This chapter summarises the financial benefits of merger. It then describes the long term financial model and looks at the new Trust's projected financial performance and position over the period 2012/13 to 2016/17.

- The new Trust will deliver merger savings of £7m between 2012/13 and 2014/15, through management and back office restructuring and clinical and non-clinical procurement efficiencies.

Gaps

The primary focus of this chapter is to summarise the financial benefits of the merger however in doing so very little information is given on how the £7m will impact on staff beyond management and back office restructuring. As such there is a very real possibility of a negative impact on staff groups by protected characteristics if redeployment or redundancies are a factor. Issues include:

Recruitment and retention of suitably qualified staff

Representation at senior levels following staff reduction plans especially BME staff

Redundancies

Staff reconfiguration and impact on flexible working arrangements

Recommendation

The Trust should adopt the following process for all restructuring in order to ensure that processes are deemed to be transparent, fair and equitable.

Proposed methodology

Stage 1: Initiation

Analysis of baseline staff equality data considered in case for review

Stage 2: Review

Further analysis of staff equality data if required)

Assess how equality groups could be impacted in options for change identified

Identify and implement actions to mitigate negative impact or to promote equality

Stage 3: Restructure

Analysis of pre and post equality data

Assess how equality groups could be impacted

Identify and implement actions to mitigate negative impact or to promote equality

Stage 4: Post restructuring review

Review how equality impact has been considered

Identify and implement actions to mitigate negative impact or to promote equality

Stage 5: Compulsory redundancy

Institutional analysis of staff equality data

Identify and implement actions to mitigate negative impact or to promote equality

In addition the Trust should ensure that interview panels are a mix of protected characteristics where ever possible and that panellists have been trained in interviewing techniques.

Due to the potential impact on the workforce the potential impact on equality has been assessed as negative and positive.

Chapter 9 The new organisation's structure and governance arrangements

Key issues covered in this chapter of relevance to EDHR

- Proposed Board and subcommittee structure including details of non-executive and executive director arrangements
- Performance reporting tool for new organisation
- Clear governance and accountability for the delivery and mainstreaming of equality, diversity and Human Rights in all areas of policy development, service delivery and workforce development.

Gaps

Agreed framework for identifying Equality objectives and measuring success.

Evidence of how Board leadership – roles and responsibilities of new board – will be aligned with Equality, Diversity and Human Rights requirements

Compliance with Public Sector Equality duty (Post & Pre-merger)

Priority given to EDHR within a governance framework

Clear articulation of the mechanism for embedding Equality, Diversity and Human Rights

Evidence that the proposed Integrated Performance Management Systems will take account of Equality and Diversity

Appropriately resourced corporate Equalities and Human Rights function

Recommendations

New Trust to prepare and publish Equality Objective from date it becomes a legal entity.

The supporting Equality and Diversity Strategy proposes a structure within which an Equality, Diversity and Human Rights Committee reports directly to the Board. This is not reflected in the paperwork forming chapter 9. Evidence shows that equality initiatives tend to fail unless they allow both for a specific, focussed drive looking solely through the lens of equality and a rigorous approach to mainstreaming the issues across all work streams. The proposed governance structure may be a standard one recommended by Monitor. But the new Trust will be one of the most diverse in the country is not serving a "standard" population, and needs an Equality Committee to ensure these issues are never allowed to fall off the agenda. Monitor's governance structure was also deemed to be not suitable for BELH which serves a similarly diverse population. As a result BELH have adopted a structure where the Equality Diversity and Human Rights Committee reports directly to the Trust Board.

The supporting Equality and Diversity Strategy commits the Trust to implementing the Equality Delivery System. The Trust should make a public declaration to this effect so as to assure its local communities of its intention to continue its equality, diversity and human rights work.

Requirements of the Equality Act to be included in the board development programme – so they are fully aware of and able to meet the requirements of the Equality Act

Performance management metrics to clearly incorporate equality, diversity and human rights metrics.

Due to the EDHR committee being removed from the highest level of governance responsibility and the lack of detail on monitoring of compliance with the Equality Act the potential impact on equality has been assessed as negative.

Chapter 10 Engagement and involvement of all stakeholders

Key issues covered in this chapter of relevance to EDHR

- This chapter provides an overview of communications and engagement activities regarding the proposed merger. It also includes a summary of the key themes raised by stakeholders and the Trusts' responses to these themes.

- Again it is important to keep in mind that the FBC is proposing a merger of organisational change and not service reconfiguration. The Trusts took advice from NHS London and legal representatives regarding statutory duties on consultation regarding merger. This advice was that under Section 25 of the NHS Act 2006 (National Health Service - Consultation on Establishment and Dissolutions - Regulations 2010) both Trusts were required to consult with their Local Involvement Networks (LINks) in relation to their proposed dissolutions. In addition both Trusts recognised the importance of, and made a commitment to, engaging with a broader group of local stakeholders.

Positive Impact

In order to ensure that information on the merger was as widely available as possible a document was produced entitled 'Stronger Together'. This was available in hard copy, through Trust websites and LiNKS websites. It was offered in large print, audio, Braille and a variety of different languages on request. A poster was published and put up around the Trusts' sites to encourage people to pick up a copy of the document. More than 12,000 copies have been circulated.

Gaps

Much of the feedback has focussed on potential changes to services even although no service reconfiguration is proposed within the FBC. Moving forward it is important to re emphasize for local communities a) this is only an organisational change merger and b) the commitment of the new Trust to engage as fully as possible should service reconfiguration issues arise in the future.

Recommendations

The communications and engagement programme leads should make full use of the existing BME networks and any other staff networks to engage with them as critical friends when carrying out further consultation work

The potential impact on equality has been assessed as positive.

Chapter 11 Integration and implementation plan

Key issues covered in this chapter of relevance to EDHR

- This chapter describes how integration will be achieved, explaining the phases of transition, key activities and milestones and how the merger process will be managed.

Positive Impact

Clear reference is made to the draft Equality and Diversity Strategy.

There is a commitment that workforce numbers are to be reduced only after following all opportunities across the two Trusts for re-deployment using a range of HR initiatives

Although not mentioned explicitly in the FBC discussion with the HR & OD work stream programme director has revealed that equality, diversity and human rights makes up one of the five work streams under this heading.

Gaps

Equality analysis on merger programmes and work streams

Measures or process to ensure, maintain and monitor consistent and improved patient experience in regards to the different protected characteristics within the crucial first year.

Data and related tools to support clinical and non-clinical work streams in the implementation of equality objectives

Recommendations

This document constitutes a high level analysis of the proposals within the FBC. As work progresses on the various work streams all areas should have an initial analysis of relevance to the Equality Duty carried out and recorded. For those areas with greater relevance detailed action plans should be drawn up and reported upon as part of the PMO reporting systems.

Work should start immediately to prepare for the publishing of Equality Objectives on the day the Trust is legally constituted.

Workforce diversity data should be collected in order for the new organisation to have a baseline for any restructuring that may take place

Workforce plans should include details of how the workforce can be reflective of the communities served by the new Trust

The new organisation should have a plan in place to tackle under representation of staff groups with regards to protected characteristics when it comes to middle and senior management.

The potential impact on equality has been assessed as negative and positive

Next Steps

The recommendations made above have been taken and presented as an initial action plan below in order to mitigate against any potential negative impact on equality that could arise.

3 Assessment and actions needed

Initial ideas for actions can go here. You will refine them further at stage 6. Please note the impact assessment will not be accepted unless group(s) affected is listed with a link to the action required. Primary areas to consider are: **age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and human rights**

Barrier	Group affected	Action needed	Responsibility	Timescale	Resources
Built environment		Ensure ICT systems are accessible	IM & T manager	Dec 2012	Within existing resources
Location	N/A	N/A	N/A	N/A	N/A
Information and communication	All	Collect equality data based upon protected characteristics of local population	AD Engagement & Equality	October 2012	Within existing resources
	All	Set up database of local organisations which represent protected characteristics	AD Engagement & Equality	October 2012	Within existing resources
	All	Collect staff equality data to have a robust baseline	AD Engagement & Equality E & D Manager	December 2012	Within existing resources

Customer care and staff training	All	Set corporate and local equality objectives by working with clinical divisions and local communities Board development programme to include requirements of Equality Act	AD Engagement & Equality AD Engagement & Equality HR & OD work stream Lead Leadership Development Lead	October 2012 January 2012	Within existing resources Within existing resources
Timing	N/A	N/A	N/A	N/A	N/A
Stereotypes and assumptions	N/A	N/A	N/A	N/A	N/A
Costs of the service	N/A	N/A	N/A	N/A	N/A

Commenting, consultation	All	Trust explicitly affirms participation of EDS	Trust Board	October 2012	Within existing resources
	All	Prepare data and set up consultation mechanisms for local communities to feed into the setting of equality objectives for the new Trust	AD Engagement & Equality E & D Manager Communications and Engagement Lead	July 2012	Within existing resources
	BME and any other staff groups	Trust to formally engage with staff networks as critical friends in any further consultation	AD Engagement & Equality E & D Manager Communications and Engagement Lead	Ongoing with quarterly reporting	Within existing resources

Specific barriers	All All	Adopt transparent and equitable process for managing organisational change Equality analysis of all work streams and programmes and projects to be carried out as BAU	AD Engagement & Equality HR & OD work stream lead AD Engagement & Equality HR & OD work stream lead PMO	October 2012 Ongoing with quarterly reporting until programmes come to an end	Within existing resources Within existing resources
Human Rights	N/A	N/A	N/A	N/A	N/A

Other	AI	Performance metrics to incorporate EDHR	Trust Executive	December 2012	Within existing resources
	All	Consider EDHR committee as reporting directly to Trust Board	Trust Board	October 2012	Within existing resources
	All	Write a paper for Trust Board to consider positive action programmes in order to tackle under representation at middle and senior management levels	Leadership Development lead AD Engagement & Equality	November 2012	Within existing resources

It is important to note that where the action plan states " To be considered as part of full EQIA" it is not to be understood as this issue has been found to have no impact. Rather it is an understanding that as the full EQIA is carried out over the coming months there will be further detailed information which will inform the corporate and departmental actions that will need to be taken.

5 Future consultation

BME staff networks, local communities, CD's, Trust Executive to help facilitate the setting of equality objectives and to assist in the review of this analysis and action plan

This analysis and action plan is seen as a live document and as such will be updated and amended regularly.

6 Action plans, targets and priorities

Action Plan to be fed back via the HR & OD work stream and the PMO office for assurance purposes.

This analysis and action plan is seen as a live document and as such will be updated and amended regularly

7 Monitoring and feedback

This document will be monitored via the HR & OD project work stream and feed back will be given regularly to the PMO

This analysis and action plan is seen as a live document and as such will be updated and amended regularly

8 Tell people what you are doing

The analysis will be published as part of the FBC. Copies of both documents will be available on Trust websites. Braille, audio and large print copies are available upon request.

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STRONGER together

The proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust

London North West Healthcare NHS Trust

Final draft Full Business Case

Executive summary

Ealing Hospital NHS Trust

The North West London Hospitals NHS Trust

Executive Summary

INTRODUCTION

This Full Business Case (FBC) makes the case for a merger of Ealing Hospital NHS Trust - Integrated Care Organisation (EHT-ICO) and The North West London Hospitals NHS Trust (NWLHT).

The FBC has been developed from the Outline Business Case (OBC) which was approved by both organisations' Trust Boards and NHS London in November 2011. Since the OBC was approved a number of important documents have been written which support the FBC (as set out in Table 3 in the final draft FBC).

It is important to emphasise and reassure readers that the business case is for organisational change, not service reconfiguration. The challenges facing both Trusts are likely to require service changes in the future but this process is being led by NHS North West London as part of the *Shaping a Healthier Future* (SaHF) programme. As described in chapter 4, SaHF will be the subject of separate formal public consultation and local scrutiny during summer 2102. The merger proposals described in this FBC are entirely separate.

Commissioners (currently Primary Care Trusts but increasingly Clinical Commissioning Groups) rightly want to change the services that they buy to ensure that they meet the standards that would be expected of a modern health service. In particular this involves care for rarer conditions requiring expert treatment in fewer, more specialised centres and care for common conditions being provided as locally as possible and ideally in or close to patients' own homes. In response the two Trusts have developed a shared service vision which aims to meet these challenges. The new Trust's vision is to provide high quality care across all three boroughs and to maximise the benefits of integrating community and hospital services for both patients and staff. The merger will also ensure financial sustainability for the new Trust.

The structure of the FBC is based on NHS guidance and includes the following chapters.

CHAPTER 3 - PROFILE OF THE TRUSTS

EHT-ICO and NWLHT are two of the seven acute Trusts serving the 1.9 million residents of North West London (NWL). Both Trusts are committed to delivering high-quality care to patients, and share a common vision for improvement. There is also a significant clinical overlap in the services

currently provided by EHT-ICO and NWLHT and both Trusts have well established clinical networks between themselves (e.g. for vascular and maxillo-facial services) but also with other local Trusts, notably Imperial Healthcare NHS Trust (ICH) which, for example, provides renal dialysis services for both Trusts.

Following establishment in April 2011, EHT-ICO comprises a single acute hospital site with more than 350 beds (and a £125m budget) and also provides community services (160 beds and £97m budget). EHT-ICO is a financially stable organisation and over time (as described in chapter 8) is projected to generate a total surplus of £18.5m by 2015/16.

NWLHT is based on two acute sites - Northwick Park Hospital (NPH) (which includes St Mark's Hospital) and the Central Middlesex Hospital (CMH) sites, with 680 beds and a budget of £369m. Over recent years NWLHT has not been able to achieve recurrent financial balance and has applied to the Challenged Trusts Board (CTB) for release of funding to pay off its historic debt[1]. Over the period to 2015/16 the Trust is forecast (chapter 8) to continue delivering a deficit in each year.

Both Trusts have had a good track record of delivering operational targets, however NWLHT and NPH in particular has struggled to deliver consistent performance against the four hour wait standard for A&E.

Current performance against clinical indicators is mixed – while both Trusts are proud of their excellent mortality rates, NWLHT is struggling to achieve this year's Health Care Acquired Infection targets.

CHAPTER 4 - COMMISSIONING STRATEGY IN NORTH WEST LONDON

Healthcare is commissioned from both Trusts by NHS North West London which includes the three local boroughs of Brent, Ealing and Harrow. All three boroughs share wide variations in current levels of deprivation, health needs and health outcomes.

In addition the boroughs face common future public health challenges, including population growth, changing demographics and an increasing prevalence of lifestyle-related diseases. Local health priorities include a greater focus on preventing disease; improving access and delivering care in the community; increasing the consistency and quality of care; improving clinical outcomes and strengthening the patient experience.

[1] As of March 2011

The local NHS and other stakeholders recognise that a change in the way services are currently organised and delivered is required in the light of these challenges. There is broad agreement among both providers and commissioners that in a budget-constrained environment, scarce resources are best deployed by delivering care in the community wherever possible and clinically appropriate, rather than in hospital.

Improving patient care will require close joint working across primary, community and acute (hospital) services, as well as greater levels of integrated care across providers and consolidation of specialist services onto fewer sites.

NHS NWL published their case for change (called 'Shaping a Healthier Future') in January 2012 and has subsequently developed a new categorisation for existing hospitals and the services that should be provided by them. These options will be included as part of a formal public consultation due to commence in summer 2012.

CHAPTER 5 - THE CASE FOR MERGER

As a result of NHS NWL's commissioning intentions, described in chapter 4, the two Trusts will need to deliver increasingly rigorous quality standards with less money as secondary care hospital income is being reinvested into providing care closer to home.

A key consequence of these plans is that, despite population shifts, it will not be possible to increase the scale of the Trusts' hospitals to meet clinical quality goals simply by growing and generating more income.

Smaller hospitals will find it increasingly difficult to fulfil commissioning standards and other quality requirements. EHT-ICO in particular, lacks critical mass in key acute specialties when compared to other Trusts and NWLHT faces similar future challenges in some areas such as A&E where the Trust has struggled to recruit sufficient A&E doctors. Furthermore, at a time when the NHS wants to concentrate as much resource as possible on direct patient care, larger organisations, through economies of scale, are better able to reduce their managerial and 'back office' overheads.

To have a sustainable future as a standalone organisation EHT-ICO would need to increase the number of key staff – particularly consultants – and increase the availability for some specialised tests and therapies on a 24/7 basis. Even if finances were readily available, critical clinical mass for EHT could only be realised through a substantial increase in the volume of work performed at EHT-ICO. If the volume did not increase then efficiency would deteriorate and some specialised teams would not have sufficient work to

reach the minimum requirement to maintain their skills and meet commissioning standards. The adverse financial environment and demanding commissioning intentions make this scenario untenable.

NWLHT, with NPH operating as a major acute site, has a larger critical mass and so has less immediate concerns about clinical sustainability but even for NWLH, additional benefits and resilience would be provided through larger teams and joint working with EHT. This is particularly important in A&E where the Trust performs poorly partly due to staffing shortages.

Both Trusts have concluded that they cannot support the new commissioning standards and reduced income forecasts alone. Put simply a merger is needed so that both Trusts can improve the quality of services for the local population by pooling clinical resources, cutting waste and duplicate administrative costs.

The Boards of both Trusts agree that, despite the tough local environment, the proposed merger will create a healthcare organisation with sufficient critical mass, scope and ambition to deliver the following vision:

> *"To provide the best quality healthcare in the best place: home, community or hospital by being responsive innovative and ambitious."*

Central to the Trusts' future vision is a greater focus on preventative care and on the needs of those with long-term conditions – healthcare needs that will largely be met in community and primary care settings. In recent years, some progress has been made towards the goal of providing effective, readily accessible care outside of hospitals. EHT has already made significant strides towards achieving this by forming an Integrated Care Organisation (ICO). This means that Ealing residents receive care from staff working in teams across traditional hospital and community boundaries. By merging the Trusts it is anticipated that it will be possible to improve care on a wider scale across three boroughs as the acute services currently within the NWLHT will also become more community focused and as a result provide more seamless care to local patients.

In addition to the economies of scale achieved by integrating a large major acute hospital with a large ICO, both Trusts believe that the merger will also benefit patients accessing both emergency and elective care. This is because the two Trusts will be able to base services around larger, more senior and more specialised clinical teams, with access to the right equipment to support best and innovative practice.

CHAPTER 6 - CLINICAL VISION FOR THE NEW ORGANISATION

To achieve the clinical vision, the new Trust will need to be a clinically led and patient centred organisation. It will aim to nurture and promote excellence in all aspects of clinical work; to listen and respond to patients and partners and to recruit, develop and retain the very best staff.

Clinical leadership and involvement is central to the success of the merger as it is only through real engagement of clinical staff that the benefits of improved patient care and efficiency will be realised. The new organisation will therefore be arranged into the following five clinical divisions led by a senior clinician as Divisional Group Director:

- Locality-based services
- Integrated medicine
- Surgical services
- Women and children's services
- Clinical support services

The locality based services divisional management structure will be based around the three boroughs and will include local GP representation at this level on the management board.

Given the strong link between delivering high quality training and clinical care and staff satisfaction, the vision for the new organisation includes a commitment to excel in teaching and training. Both Trusts have a strong track record of teaching and training medical and non-medical staff and this will be further developed as part of the new Trust. The new Trust will also need to ensure that training does not suffer during the transition phase.

Finally the new Trust plans to maintain a robust approach to research, development and innovation based on current good practice within existing Trusts.[2]

CHAPTER 7 - CLINICAL BENEFITS OF THE MERGER

The new organisation aims to deliver greater care of a higher-quality in the community, with an increased access to specialised services across the three boroughs. Staff will have new career opportunities, as well as better training and support. The local health economy will benefit from more efficient resource allocation within a stable and viable organisation. This chapter

[2] NWLHT currently holds second pole position in the North West sector for Comprehensive Local Research Network (CLRN) income and EHT has a large scale observational study relating to cardiovascular disease in its portfolio that accrues well against CLRN targets.

explains how clinical benefit can be achieved even in the short term, without significant service reconfiguration.

Case studies have been prepared to show how the potential benefits of merger will be experienced, with a particular focus on better outcomes and an improved patient experience.

In summary, as well as providing a safe route for business continuity, the proposed merger offers opportunities to organise the delivery of healthcare services in new and innovative ways. The new Trust will have the potential to improve patient experience and clinical quality, while reducing total cost and making the most of the expertise that is available.

CHAPTER 8 – FINANCIAL EVALUATION

Clinical quality is the key driver for the proposed changes and the Boards of both Trusts believe that the merger will deliver significant clinical benefits for patients. At the same time the merger will also provide important financial benefits, without which clinical delivery would in any event suffer. As described in chapter five, without an increase in the scale of operations and the opportunity to develop services along patient pathways, it will prove increasingly difficult for the individual Trusts in the longer term to continue to deliver the additional efficiencies and productivity improvements required to meet anticipated reductions in overall contracted income and invest to enhance quality of care.

A financial assessment of current commissioning intentions and the likely effect on Trust income over the next four years, demonstrates that EHT-ICO would continue to deliver a surplus (£10m annually by 2015/16) and confirms that NWLHT is not financially viable if it remains as a standalone Trust.

The challenge for EHT-ICO is not primarily financial as the forecast activity which underpins the positive financial position may not be sustainable in the future. As described in Chapter 4 Commissioners will increasingly only commission services from sites that can meet the rising quality standards expected, which Ealing may struggle to meet (examples are described in Chapter 7). The solution for both Trusts is a merger that makes them stronger together as it will create an organisation which has both the clinical critical mass and the financial basis required to become a Foundation Trust.

In the short and medium term, savings will be generated from improving productivity; reducing headcount and temporary and agency staff spend; reducing “back-office costs”; capturing merger synergies; reducing the costs of hospital stay by improving community care and improving estates utilisation. By 2015/16 annual savings will equate to over £140 million.

The analysis in Chapter 8 shows that the new Trust will have the capacity to deliver a 1% surplus (£6.3m) by 2015/16, have the financial sustainability required for authorisation as a Foundation Trust and have a closing cash balance of £57.9m which would meet the Monitor requirements.

To achieve this sustainable state, the new Trust would require a total of £96.5m of external funding support. This amount is made up as follow:

- Non recurring transitional funding of (£16.2m) to cover short term deficits of the merged Trust in 2013/14 and 2014/15
- Future liquidity requirements of (£27.3m)
- One off implementation costs of merger (£30.4m) over a four year period
- Historic deficits of NWLHT and PDC support (£22.6m)

NHS North West London has committed £33m, funding support principally from the Challenged Trust Board (CTB). The balance of the funding support required (£63.5m) will be resolved by further discussion with NHS London, DH and the Commissioners to agree the source of the cash support requirements through to 2015/16. From 2015/16 the new Trust would be viable without further need for financial support and would deliver a significant return on investment of £20.1m by 2015/16 (Table 15) for the taxpayer. Without this support the organisations will continue to record declining financial performance and need ever increasing subsidies.

NWL Commissioners have indicated their wish to re-configure clinical services in the region and Commissioners have prepared a PCBC, including financial models showing the impact of the changes on individual trusts, which identifies a preferred option and two alternative options. Both Trusts are familiar with the modelling undertaken by the Commissioners and the main assumptions supporting the modelling. The modelling shows that after service changes there would be a deficit of between £2m and £6m depending on option selected for implementation. The modelling also shows that NWLHT (as an individual Trust) would require a subsidy of between £12-15m to achieve a 1% surplus in 2014/15 under the preferred option and the two alternative options. No subsidy would be required for EHT.

The Commissioners modelling is on a pre-merger basis. The merged Trust LTFM shows that the Trust will generate merger savings of £21.1m by 2014/15. This coupled with the annual surpluses of over £3.3m being generated by EHT ICO – Community Arm by this time more than offset the deficit identified by Commissioners and still permits the merged Trust to be financially sustainable and meet the Monitor FT requirement of 1% surplus.

CHAPTER 9 – THE NEW ORGANISATION'S STRUCTURE & GOVERNANCE ARRANGEMENTS

The new organisation will be centred on the needs of patients and will step beyond traditional divisions between specialist, acute and community care. In order to deliver the clinical vision described in chapter six the new organisation's clinical vision needs to be more than simply a response to likely financial or organisational challenges. The new Trust will need to deliver high-quality care to the diverse local population in an accessible and effective manner. Its creation will enable new and innovative services to be delivered and improve patient choice and competition.

As described previously, the clinical divisions will form the driving force of the merged organisation, with responsibility for continuous improvement in the quality of patient services in line with best practice and reflective of the new organisation's vision and values.

At the same time, the new Trust Board will maintain an appropriate balance of skills and experience to ensure that it is fit for purpose as both an NHS Trust and ultimately a Foundation Trust.

The Trust Board will delegate its assurance functions to the following five committees; Audit Committee, Remuneration and Appointments Committee, Quality and Governance Committee, Finance, Investment and Workforce Committee and Risk Committee.

The Chief Executive, executive directors[3] and non-board directors will be responsible for the operational management of the Trust.

The Trust will adapt the structure to include a Council of Governors as it moves towards Foundation Trust status.

CHAPTER 10 – ENGAGEMENT & INVOLVEMENT OF STAKEHOLDERS

Given the importance of developing an FBC that has contribution from, and the support of local stakeholders, communication and engagement was identified as a priority early in the merger process. A communications and engagement strategy for the programme has been in place since before the Outline Business Case (OBC) was written, to ensure that local people are kept informed and given an opportunity to express their views. More than 12,000

[3] The executive members of the Trust Board will comprise the Chief Executive, Chief Finance Officer, Medical Director and Chief Nurse and Chief Operating Officer.

copies of a summary booklet[4] setting out why the merger is being considered and the benefits for patients and staff have been circulated to MPs, GPs, CCGs, local authorities, staff and voluntary organisations. A microsite was launched at the beginning of February 2012 bringing together all relevant information about the merger into one place.

More than 60 meetings and events have been held with stakeholders including staff, Overview and Scrutiny Committees, CCGs, LINks, MPs, GP commissioners and local patients' advocates including the West London Citizens[5]. Three borough-wide deliberative events for stakeholders were held in May and June 2011 and feedback from the events was used in development of non-financial evaluation of scenarios included in the OBC. More recently the three LINks organisations covering Brent, Ealing and Harrow held events in December 2011 and January 2012 to seek the view of the public and their members on the proposed merger.

A range of clinical engagement events have also been held with clinicians across the two Trusts and GPs culminating an event[6] attended by more than 60 staff, facilitated by The Kings Fund.

The key themes that emerged consistently from the engagement process included:

- Transport links and access in general
- Concerns about potential impact of the merger on local services
- Ability to achieve savings targets
- Investment in community services
- Support for staff during the change process
- Is bigger really better?

Although the merger itself will not directly lead to major service change, for many stakeholders these two issues were seen as the same. These themes are addressed in detail in Chapter 10.

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4 Stronger together - The proposed merger of Ealing Hospital NHS Trust and The North West London Hospitals NHS Trust. November 2011

5 A well represented local charity with members drawn from community groups in West London

6 The aim of the event was to support the development of effective clinical teams in a new merged organisation with a focus on integrated care.

CHAPTER 11 – INTEGRATION & IMPLEMENTATION PLAN

As described in previous chapters, new organisation will be patient focused, clinically led and financially robust. It will need to provide the highest quality of care; adhere to patient safety standards; support effective governance processes; remain committed to staff; be responsive to the needs of commissioners; provide transparent communication with stakeholders and demonstrate strong clinical leadership.

These objectives must be delivered within specified time frames, through a phased implementation plan with minimal service disruption. A robust programme management and risk management approach to integration delivery and benefits realisation has therefore established and is described in this final chapter.

CONCLUSION

This FBC has assessed the implications of commissioners' future plans and the requirements of national, regional and Royal College guidance (see chapters 4 and 5). These requirements are expected to result in less demand (and ultimately income) for acute services as there is greater investment in out of hospital care. This coupled with the clinical drivers of increased medical sub-specialisation and need for greater critical mass, means that the two Trusts would struggle to be clinically and financially sustainable in the future if they remained independent (see chapters 5 and 8).

A merger of the two Trusts will provide real benefits for patients, staff, commissioners and the local population (see chapters 6 and 7). It will create a combined Trust which is both an integrated community and a large acute provider, able to develop more effective clinical care for patients both in the hospital and the community. At the same time, the merged Trust will have the scale and critical mass needed to provide the highest quality specialist services on both a local and regional basis. It will also by 2015/16 be well on the way to achieve the financial strength required for authorisation as a Foundation Trust (chapter 8).

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	Health Partnerships Overview and Scrutiny Committee 18th July 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Shaping a healthier future consultation

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny Committee will be aware that NHS North West London has been working on Shaping a healthier future, its programme for health improvement in North West London. The committee received a report at its previous meeting on the project, including an update on the Joint Overview and Scrutiny Committee that has been formed by North West London boroughs to scrutinise the proposals for service change.

1.2 Since the committee's last meeting, the public consultation on Shaping a healthier future has begun. Whilst the consultation is about more than the location of major hospital services in North West London, it is this element that has attracted most attention in the lead up to consultation. There are three main options out to consultation in relation to hospital services:

Option A (the preferred option) -

Major hospitals – Northwick Pak, Hillingdon, St Mary's, Chelsea and Westminster and West Middlesex
Local hospitals – Ealing and Charing Cross
Elective hospital – Central Middlesex
Specialist Hospital – Hammersmith

Option B –

Major hospitals – Northwick Park, Hillingdon, St Mary's, West Middlesex and Charing Cross
Local hospitals – Ealing and Chelsea and Westminster
Elective hospital – Central Middlesex
Specialist Hospital – Hammersmith

Option C –

Major hospitals – Northwick Park, Hillingdon, St Mary's, Ealing and Chelsea and Westminster
Local hospitals – Charing Cross
Elective hospital – Central Middlesex
Local and elective hospital - West Middlesex
Specialist Hospital – Hammersmith

1.3 Members will be most interested in the impact of these changes on services in Brent. Under all of the consultation options, both Northwick Park and St Mary's Hospital will remain major hospital service sites, with a full range of A&E and maternity services, as well as the services required to support these functions such as emergency surgery. Central Middlesex is recommended to become a local hospital and an elective centre. The consultation document says the following about Central Middlesex Hospital:

> "We have not proposed Central Middlesex Hospital as a major hospital in any of the consultation options. We have recommended that Central Middlesex Hospital should not be a major hospital but an elective hospital with local hospital services. This is because it is already providing these services, its major A&E services are already under pressure (A&E emergency round-the clock care had to be suspended in late 2011 because not enough senior emergency care doctors were available on-site), essential services for a major hospital – emergency surgery, paediatrics and maternity – are not provided on-site and patients could access these major emergency care services elsewhere in other nearby hospitals". Page 56 of Shaping a healthier future consultation document.

1.4 Although the council is participating in the North West London JOSC, it is still able to respond to the consultation setting out its comments in relation to the proposals. Brent Council's response would, understandably, be more Brent focussed than the JOSC report and response to the consultation, which has to reflect the views of all of the participating boroughs. The committee should consider how it wants to respond to the consultation, which closes on the 8th October.

1.5 Officers from NHS Brent and North West London NHS Hospitals Trust will be at the committee to answer questions about the Brent elements of the Shaping a healthier future proposals.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee should consider the Shaping a healthier future consultation documents and question representatives from NHS Brent on the plans for services in the borough. Members should also consider how they wish to respond to the consultation.

Contact Officers

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Crystal Mark 20288
Clarity approved by Plain English Campaign

NHS
North West London

Shaping a healthier future

Consultation document

Shaping a healthier future

Contents

What this document is for

This document sets out proposals to improve your local NHS services in North West London as part of a programme called 'Shaping a healthier future'.

It is a consultation document and we would like to hear your views on the changes that we propose to make. We have distributed the document widely throughout North West London and neighbouring areas where people use services in North West London. The London boroughs defined by the NHS as North West London are Brent, Ealing, Hammersmith and Fulham, Harrow, Hillingdon, Hounslow, Kensington and Chelsea, and Westminster.

'Shaping a healthier future' is being taken forward by eight clinical commissioning groups (CCGs), made up of GPs representing NW London's eight primary care trusts (PCTs). They have worked with hospital doctors, nurse leaders, providers of community care such as mental-health services, social services, patient and volunteer groups and charities to develop the proposals.

If you would like to know more about the extensive work behind this document, please read our pre-consultation business case (PCBC). You can find this on our website at www.healthiernorthwestlondon.nhs.uk

Or, you can order a copy from our Freepost address or Freephone number which are both shown on the next page.

?

Throughout this document you will see a number of questions in boxes, looking like this. These questions relate to the response form that comes with this document, which contains the actual consultation questions we would like you to answer.

Please read the consultation document all the way through and then, in the response form, give us your answers to these questions. In the response form we have shown which sections of the document cover the issues raised by each of the questions. Please refer back to these sections as you answer the questions.

If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so in the box at the end of the response form.

You can fill in the questions on the printed response form and post it to our Freepost address:

FREEPOST SHAPING A HEALTHIER FUTURE CONSULTATION

This must be written exactly as it is shown above (in capital letters and on one line) and you will not need a stamp.

Or, you can fill it in online on our website:

www.healthiernorthwestlondon.nhs.uk

If you have any complaints about the consultation please contact:

Lynne Spencer,
Head of Corporate Affairs,
NHS NW London,
Southside,
105 Victoria Street,
London,
SW1E 6QT

We must receive your response form by no later than 8 October 2012.

This document is also available in other languages, in large print, and in audio format. Please ask us if you would like it in one of these formats.


0800 881 5209


consultation@nw.london.nhs.uk

Foreword

Foreword by the chairs of the NW London clinical commissioning groups

Our aim is to deliver the best possible healthcare to our patients. But people's health needs are changing, and we aren't able to deliver care to the standards we would like. We believe we need to change the way we deliver healthcare now, so that we can provide high-quality care in the medium and long term.

This need for change in the NHS is partly a response to ongoing changes in the population. NW London is growing, people are living longer, and more people are developing conditions such as diabetes and obesity. This is putting pressure on our health services. We need a system where we can deliver the right kind of healthcare, in the right setting.

In many cases, the best setting isn't in hospitals. We know that increasing the amount of care delivered closer to your home will help care to be better co-ordinated, and improve the quality of that care and its value for money. When people do need hospital care, we have shown that making some services more central will mean that patients always have access to the best possible care.

As the chairs of the eight clinical commissioning groups for NW London, and leaders of this programme to deliver this change, we have made four main commitments which support our vision for how services should work in the future.

The first is a commitment to help people take better care of themselves, understand where and when they can get treatment, and understand different options for treatment.

Secondly, when patients have an urgent

healthcare problem, we are committed to making sure they can easily consult a GP or community-care provider 24 hours a day, seven days a week by phone, email or face-to-face.

Our third commitment is that if patients need to see a specialist or receive support from community or social care services, this will be organised quickly and GPs will be responsible for co-ordinating their healthcare.

Finally, if patients need to be admitted to hospital, we are committed to making sure the hospital will be properly maintained and up to date and a place where they can receive treatment delivered by specialists, 24 hours a day.

We will need to make significant changes to achieve these commitments, and we will have to make some difficult decisions, but we believe the changes are essential. The changes may be substantial, but the rewards of getting it right will be too, with better healthcare, better support, more lives saved, and a sustainable, efficient system.

Dr Ethie Kong
NHS Brent CCG Chair

Dr Ruth O'Hare
NHS Central London (Westminster) CCG Chair

Dr Mark Sweeney
NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG Chair

Dr Mohini Parmar
NHS Ealing CCG Chair

Dr Tim Spicer
NHS Hammersmith and Fulham CCG Chair

Dr Amol Kelshiker
NHS Harrow CCG Chair

Dr Ian Goodman
NHS Hillingdon CCG Chair

Dr Nicola Burbidge
NHS Hounslow CCG Chair

Foreword by the Medical Director of 'Shaping a healthier future'

Dr Mark Spencer

As a doctor trained at Charing Cross Hospital and as a GP trained at Hammersmith Hospital, I have been a GP in Acton for 23 years. I reluctantly became involved in buying services for my patients as a fundholding GP in the 1990s, but found that my patients benefited if I paid more attention to information that showed where the best care was available and that together we could work with hospitals to improve some stages of care.

Over the last 10 years it has become increasingly clear that the health system locally needs to change – and not just a little bit.

As I talk to people, they complain about access to their GP practice, and about a poorly co-ordinated system, and while they sometimes talk about spectacularly great treatment, they too often tell me about the lack of care and communication.

But as I look at the examples of best practice, and evidence that shows that specialist teams can do better in some conditions when working as part of a larger team, I realise that the good outcomes we sometimes get are more often because doctors, nurses and other care workers make that happen despite the organisations they work for, rather than being supported by them.

We have too many small hospital units in North West London that can't provide the best specialist care or make sure that an expert is available round the clock. This provides average, rather than the best, care. By concentrating specialist care onto fewer major hospitals and still providing excellent access to networked care at local hospitals we can get better care. This also allows investment into community and primary care, which is where most patients are treated.

I was leading a local group of GPs, but have had the opportunity over the last year to co-ordinate and work with GPs with similar cares and concerns for people across North West London. We have worked with hospital doctors and nurses and considered how we can make things better, and affordable. It is this group of GPs, supported by senior doctors from every hospital in the region, that has led this work and drawn up these recommendations.

Change is rarely welcomed, and many attempts have been made in the past to improve care in North West London. But as clinicians come together to take on the responsibilities of making sure the best care is available for the local population, we have an opportunity that we must take. If we don't take this opportunity we will face thinly spread services or unplanned closures on safety grounds. But if we work to make these changes, we will save many lives and improve the care that people experience every day. This is an opportunity not to be missed.

I do hope that you read this document, consider and discuss it. We really haven't made any decisions yet – our recommendations will benefit from your response.

Dr Mark Spencer
Medical Director, *Shaping a healthier future*

Foreword by the Chair of the Joint Committee of Primary Care Trusts

Jeff Zitron

For those of us who live in North West London, having a strong local NHS is a top priority. Many residents owe their lives and good health to the quality of our staff and facilities. However, others are not able to access the services they need or do not always receive the highest standard of care.

Demands on the NHS are increasing because of its very success – for example, people are living longer and medical advances mean more conditions can be treated than ever before. As a result, standards of care keep on rising, so the NHS must change to keep pace.

This document explains why and how health services in North West London need to change, and describes options for achieving this. The proposals within the document have been developed by local doctors, nurses and other healthcare staff, in consultation with patients, councils and care organisations. We propose major changes to how services are provided in hospitals and within the community. The proposals draw on experience – in North West London and beyond – of how health services can be improved by making better use of staff expertise, buildings and funds.

Before any decision is made on these proposals, we are asking the public in the areas affected for their views. This consultation is being overseen by the NHS primary care trusts (PCTs) in North West London, together with other PCTs whose residents may be affected by the proposed changes. The joint committee formed by these PCTs will consider the results of the consultation, and will then decide whether changes should be made and, if so, what these changes should be.

We are very keen to hear your views. As well as reading this document, we hope that you are able to take part in other consultation events (see our website at www.healthiernorthwestlondon.nhs.uk for more details). 'Shaping a healthier future' is about planning how we can have the strongest local NHS possible in the years ahead and I hope you will be able to contribute to this.

Jeff Zitron
Chair, NHS North West London and the Joint Committee of Primary Care Trusts

Summary

'Shaping a healthier future' proposes changes that will improve care both in hospitals and the community and will save many lives each year. This summary explains how.

We look after nearly two million people in NW London and have high aims for the way they are cared for and the services they receive. Our staff are totally committed to this high-quality care, but need to have the right workforce, skills and surroundings to deliver this for patients. Increasingly, a number of different factors in NW London are making it very difficult for us to look after patients in this way.

These factors include the challenges of looking after a growing and ageing population, with too few specialists in hospitals to provide high-quality round-the-clock care, working from inadequate NHS facilities, and working within an increasingly tight budget. These challenges need to be met – or the NHS and its services in NW London will deteriorate. This would mean inequalities continuing, people dying unnecessarily, hospitals and other services failing, hospitals being unable to recruit and keep staff, and some NHS trusts facing severe financial pressure.

Since it would be irresponsible not to tackle these challenges and simply allow patients to get a worse service, we (GPs, hospital doctors, community providers, nurses, and wider NHS staff) have looked at ways in which health services are being improved in London and around the world to develop a vision for healthcare in NW London.

We have based this vision on the principles that you should have:

- the support you need to take better care of yourself;
- a better understanding of where, when and how you can be treated;
- the tools and support you need to better manage your own medical condition;
- easy access (24 hours a day, seven days a week) to primary-care clinicians such as GPs – by phone, email or in person – when you need to be seen urgently;
- fast and well-co-ordinated access to specialists, community and social-care providers, (this access would be managed by GPs); and
- properly maintained and up-to-date hospital facilities with highly trained specialists available all the time.

The way in which we would deliver this vision, which would meet all these demands, is by:

- bringing care nearer to you so that as much can be delivered as close to your home as possible;

- centralising hospital care onto specific, specialist sites so that more expertise is available more of the time; and

- incorporating all of this into one co-ordinated system of care so that all the organisations and facilities involved in caring for you can deliver high-quality care and an excellent experience, as much of the time as possible.

We have developed standards based on the best available evidence to make sure that quality improves wherever care is being delivered, whether that is close to home, in emergencies, or in situations where specialist treatment is needed. We have developed new patient pathways – that is, the different stages of NHS care you may go through as a patient – to improve the ways different types of common conditions are treated. When they are put in place they will help us to improve the way you are cared for, and save more lives.

Delivering this vision will not be easy. It will mean changes to the way in which people work, where money is invested and the settings (places) in which healthcare is delivered.

As part of our proposals, we have described eight settings of care –your home, your GP's practice, another nearby GP practice (care network), a health centre, a local hospital, a major hospital, an elective hospital and a specialist hospital.

GP practices will work together to serve their patients, making the best use of their skills and resources to improve quality and access to services. Networks of GP practices will work with other providers of health and social care services to deliver co-ordinated healthcare to the local community. We have developed plans to put this in place for each borough. We have set aside up to £120 million to deliver the changes.

Hospitals will also need to change in order to improve quality. We have recommended that all nine current acute hospitals in North West London (Charing Cross Hospital, Chelsea and Westminster Hospital, Central Middlesex Hospital, Ealing Hospital, Hammersmith Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital) should continue to provide local hospital services, including an urgent care centre and outpatient and diagnostic services. (This urgent care centre is one which is open 24 hours a day, seven days a week.) We also recommend that five of these hospitals are major hospitals, providing a full A&E service, emergency surgery, maternity and inpatient paediatric services.

We have recommended that specialist hospitals should all stay largely as they are. The Hammersmith Hospital will become a specialist hospital, keeping all its current specialist services, as well as providing local hospital services including an urgent care centre on or very near to the current site.

We have recommended that Central Middlesex Hospital be an elective hospital as well as a local hospital with an urgent care centre. It should not be a major hospital because essential services for a major hospital – emergency surgery, paediatrics (children's services) and maternity – are not provided on-site, and because patients could use these major emergency care services elsewhere in other nearby hospitals. This means Central Middlesex Hospital will continue to provide most of the services it does already and will provide an expanded range of planned care.

We have also recommended that Hillingdon Hospital and Northwick Park Hospital should be major hospitals. This is due mainly to their location. If either of these hospitals did not

provide this more complicated healthcare, people in surrounding areas would, on average, have to travel too far to get to the next hospital providing those kinds of services.

If these proposals are accepted – with two of the five proposed major hospitals at Northwick Park Hospital and Hillingdon Hospital, and Central Middlesex Hospital as an elective hospital – we propose that services at the remaining three major hospitals should be distributed evenly across NW London to keep the effect of changes on local residents to a minimum. This means that there would be a choice of:

- one major hospital at either Charing Cross Hospital or Chelsea and Westminster Hospital;
- one major hospital at either Ealing Hospital or West Middlesex Hospital; and
- one major hospital at either Hammersmith Hospital or St Mary's Hospital.

We have assessed these choices in detail, looking at which would deliver the best clinical quality of care and access to care, whether they are affordable and can be delivered, and which would be best for research and education, and this has resulted in three options for the public to consider.

	Option A	Option B	Option C
St Mary's	Major hospital	Major hospital	Major hospital
Hammersmith	Specialist hospital	Specialist hospital	Specialist hospital
Charing Cross	Local hospital	Major hospital	Local hospital
Chelsea & Westminster	Major hospital	Local hospital	Major hospital
West Middlesex	Major hospital	Major hospital	Local hospital and elective hospital
Ealing	Local hospital	Local hospital	Major hospital
Central Middlesex	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital
Northwick Park	Major hospital	Major hospital	Major hospital
Hillingdon	Major hospital	Major hospital	Major hospital

We prefer option A because it:

- will improve quality of care;
- makes good use of buildings;
- represents the best value for money;
- is the easiest option to carry out; and
- supports research and education.

We have considered carefully whether there should be a 'preferred option' to put to the public, since the three options – A, B and C – are all potentially suitable. However, because the Joint Committee of Primary Care Trusts, who will make the final decision on any changes, believe that option A would give the greatest benefits for NW London, it would be misleading not to say so. However, this is also a consultation aimed at gathering people's views. So we are putting all three options forward and inviting your views on which option will have the greatest benefits.

If Charing Cross Hospital is not a major hospital, we are proposing that the hyper-acute stroke unit at Charing Cross Hospital moves to be alongside the major trauma centre at St Mary's Hospital. The London-wide stroke and major trauma consultation carried out in 2009 by NHS London preferred putting hyper-acute stroke units on the same site as major trauma centres, as they need similar back-up and support.

Finally, we propose that the Western Eye Hospital is moved to be alongside the major hospital at St Mary's Hospital. This will improve the quality of care for patients.

We are now consulting everyone in NW London about these options for change to give them the chance to give their views and comments. We have not made any decisions and your feedback and explanations of how we could do things differently or better really can make a difference. In this document, we have asked you specific questions on each of the changes that we are proposing. The consultation will run from 2 July to 8 October 2012. We will then spend a few months looking at your responses, and make a final decision in early 2013.

If these changes are agreed, it will take at least three years to put them in place. We are already putting in place services that can be provided in the home, GP surgeries and health centres and only once these services are running successfully will we make changes to hospitals.

1. Describing the NHS in NW London

We look after nearly two million people in NW London, providing the best possible care with the resources available.

Local GPs, hospital doctors and other clinicians – including nurses, midwives, pharmacists, those providing community services, and many others – are devoted to delivering the highest-quality services they can.

We do this because we are committed to our patients within the eight boroughs. In NW London there are 10 acute and specialist hospital trusts, 423 GP practices, two community trusts and two mental-health trusts.

The NHS in NW London

Hospitals in NW London

8 London boroughs
2 million people
£3.4 billion annual health budget
More than **400** GP practices and **1100** GPs
8 clinical commissioning groups
10 acute and specialist hospital trusts
2 mental-health trusts
2 community-health trusts

The rich diversity of NW London, with its hundreds of different communities and wide range of people, makes delivering healthcare a demanding challenge. Every single employee of the NHS understands this and is committed to meeting the challenge. It is what the NHS was created to do – to care for its patients, no matter how complex or difficult that might be.

This means delivering more care in surroundings which are better for patients – for example in community facilities, GP surgeries, and in the home. It means making sure that centres of excellence, such as the hospitals in NW London, have access 24 hours a day, seven days a week, to the best doctors, equipment and back-up.

To provide services of the highest quality across this diverse part of London, we need to have the right resources. We need a high-quality workforce of expert, well-trained colleagues, the latest equipment and technology, backed by world-class research and education, and the best possible surroundings in which to work.

If you live in NW London, it means providing care for you across the many organisations that are involved in that care, so you always know what is happening, have full access to the best advice when and where you need it, and if things do not go as planned you know you can quickly get the very best back-up.

These might seem obvious and entirely understandable requirements for a health service, given the importance to the NHS of caring for so many people across so many boroughs. But it is easy to lose sight of just how complex and challenging the health needs of an area can be, and just how challenging it can be to meet these needs.

Increasingly, many different factors in NW London are making it very difficult for us to look after our patients in this way – which may include you. The next part of this document explains why.

2. The challenges facing the NHS in NW London

There are a number of challenges facing the NHS as a whole and those of us who deliver health services in NW London.

Many of the challenges are part of the nature of a thriving, bustling, successful city. Some of them apply only to certain communities and areas, others are the same as those faced by major cities the world over.

Population challenges

- A growing population. NW London is a very densely populated area, and over the next 10 years the number of people living here is expected to increase from just under 1.9 million to 2 million. The sheer number of people needing care, 'from cradle to grave', represents a major challenge for the NHS.

- A population with different life expectancy. NW London varies hugely from place to place in economic terms, with very poor and very wealthy households often living side by side. And health varies with wealth: the poorer you are, the more likely you are to suffer ill health. Within NW London, there is a 17-year difference in the life expectancy of those living in the most deprived wards, compared with those in the wealthiest wards. These differences can be caused by many things, such as living conditions, diet, levels of smoking and drinking, access to sport and leisure facilities, and even language barriers. Better healthcare cannot overcome all these things but it can make a major difference to them, and is known to reduce inequalities between people.

- An ageing population. In NW London the good news is that life expectancy is improving and so people are living longer. Ten years ago, life expectancy in NW London was 77 years for men and 82 years for women. Today, it is about three years longer. For the NHS, this increases the pressure on services because older people are more likely to develop long-term health conditions such as diabetes, heart disease, breathing difficulties and dementia.

- A population with modern lifestyles. Poor diet and lack of exercise are the hallmarks of a typical, western lifestyle. They lead to increased rates of obesity and diabetes and, in NW London, we are treating more and more of these conditions. Similarly, smoking is the UK's single greatest cause of preventable illness and early death, and alcohol abuse (which is increasing in NW London) is leading to increasing rates of death from liver disease and other conditions.

Clinical challenges

- It is difficult for people to get to see a GP when they need to and too many people end up in A&E. 75% of people say they manage to see their GP when they need to but this means that one in four patients in NW London feels it takes too long. The same number feel they are not treated with care and concern by their GP. These satisfaction rates are below the national average.

- At the same time, NW London has more A&E departments per person than other parts of the country and more people than average use A&E services. This is partly because people who cannot access primary care (such as GP services) often end up going to hospital instead. But providing healthcare through A&E is more expensive, and lacks the kind of co-ordinated care that a GP can provide because, for example, they know the patient's family and their health history. Many GPs offer good-quality care, but for too many patients that care is not available when they need it.

- More people are now living with long-term medical conditions, such as diabetes, heart disease, and respiratory problems such as asthma, which are creating particular problems in NW London. One complication of diabetes for example is reduced blood flow to the legs. If not treated early, this can lead to amputation. When people are managed by GPs with specialised clinics, supported by a diabetic nurse, amputation is much less likely to happen. But not everyone in NW London has access to such a service. The 'integrated care pilot' we describe in section 4 has already improved outcomes for diabetics, but NW London still needs local specialist services to improve treatments.

- Too many elderly people end up in hospital when, with appropriate care outside hospital, they could be treated in the community and looked after at home. There are good reasons for caring for people outside hospital, because elderly people are at risk of developing further conditions in hospital. Equally, at the end of people's lives, the NHS needs to do more to support them to die at home if this is what they want. In NW London, only 18% of people die at home compared with a national average of 23%, even though 54% of patients say they would prefer to die at home.

- As shown by the reorganisation of stroke services in London (see section 4), there is clear evidence that in emergency cases, having senior hospital staff on hand means a better outcome for the patient. In other words, people suffer fewer complications and are less likely to die when there is a senior doctor there to care for them when they arrive seriously ill. Statistics show that in London as a whole, people who are admitted to hospital as an emergency case at the weekend are 10% more likely to die than people who are admitted during the week. At present, the number of senior doctors available drops by more than half at many London hospitals during the weekend. Solving this issue could save 130 lives in NW London every year.

- The number of women who need maternity services is increasing and pregnancies are becoming more complicated. The rate of maternal deaths in London has doubled in the last five years, reaching twice the rate in the rest of the UK. Many of these deaths could have been prevented. Babies born outside of normal working hours are also at a higher risk of dying. This is associated with a lack of access to senior staff at these times, and maternity units cannot meet recommended midwife staffing

levels. We also do not have enough nurses to care for sick babies in NW London (we have the highest vacancy rate in London) and we do not have enough senior doctors to provide round-the-clock care for children in hospital.

- These issues won't be solved simply by training and hiring more doctors. Those doctors also need experience of dealing with complications regularly, so they can provide the best specialist care. If they do not see enough patients, they lose their skills and cannot provide such high-quality care. If they are spread across many hospitals, doctors will not get that experience.

NHS buildings and facilities challenges

- You might think having lots of big hospitals would help if a population has many health problems, but this is actually not the case, and NW London proves the point. The fact that there are a lot of big hospitals here causes more problems than solutions. With 50% more building space per hospital bed in NW London than in the rest of the country, it means:

> we spend much more on hospital maintenance and running costs than in many other places and this means we have less money to spend on services such as GPs than in other parts of the country;
> two-thirds of hospitals in NW London would ideally need significant investment and refurbishment to meet modern standards. The 'backlog' maintenance bill to correct just the very worst issues is around £53 million; and
> there are so many big expensive NHS buildings in NW London that even with this level of spending on maintenance, NHS buildings in NW London are generally not in a good condition.

- The best way to treat a population with lots of increasing health demands is actually to spend more money on services outside hospitals – and the more money spent in the community, the better the overall health of the population becomes.

- Equally, some health services in NW London are delivered from very modern, up-to-date facilities which have the latest technology. Clearly it would be a poor decision not to make the most of these buildings, especially at a time when the NHS cannot afford to find and buy new land and build new hospitals.

Financial challenges

- Not surprisingly, looking after such a large population with so many health needs costs a lot of money and the NHS currently spends approximately £3.6 billion a year in NW London – some 24% of all NHS spending in London. But as we all know, the world, the UK and London are facing particularly difficult economic times right now. Although the Government has promised to protect health budgets, the amount of money available to the NHS in real terms is likely to increase only very slightly in the years up to 2015.

- In other words, keeping up with new technology and better treatments and managing the health needs of a population that is getting older means that the NHS needs to find an extra £20 billion a year by 2015. In NW London we estimated that by 2014/2015 we would need an extra £1 billion a year. However, we already know that there isn't anywhere near this amount of money available. We have to find savings of at least 4% a year – something which has never been done by the NHS before – by becoming more productive, by changing the way we deliver services and by doing what we can to reduce demand for services. Unless things change, we predict that most of the hospitals in NW London will end up in financial difficulties.

- It would be wrong to say the NHS, and these proposed changes, are driven mainly by the need to save money. We are actually first and foremost driven by the challenge of delivering high-quality care. But money is an important consideration.

3. What will happen if we do nothing?

Even with all the challenges facing the NHS, why is there a need for such drastic change?

Surely the extra money should just be found, more doctors and nurses recruited, buildings repaired and more community facilities built? Then what is now pretty good, would become very good. If only it were that easy. Unfortunately, the situation facing the NHS in NW London is a lot worse than this, and needs more drastic solutions. The fact is, if nothing is done within the next few years, some major things will start going very badly wrong with the NHS in NW London:

- Inequalities would continue and perhaps get worse. Currently people in some parts of NW London die on average 17 years earlier than those in nearby areas. This is neither fair nor reasonable and we need to try to reduce those differences.

- People would continue to die unnecessarily. A recent study showed patients treated at weekends and evenings in London hospitals – when fewer senior doctors are available – stand a higher chance of dying than if they are admitted during the week. We need a system that allows all of our hospitals to benefit from having senior, expert consultants on-site at all times.

- Our dependency on hospital services would continue when this is not the best use of resources – resources which could be better used to help people to stay well in the community. The issue of the current poor state of many of our buildings would not be dealt with – two-thirds of our hospital buildings need upgrading.

- Existing hospital trusts would be under severe financial pressure, which means they could literally run out of money. And while the NHS can cope with some financial losses, this is obviously far from ideal and the deeper 'into the red' that trusts go, the more difficult it is to keep services running, to keep staff and maintain morale, and to provide high-quality patient care. As there is a limit to the money available, some of the hospitals in NW London would simply have to stop providing services. Crucially, this would happen in a disorganised way – meaning a worse effect on patients and staff.

- There would also be problems with the NHS workforce. As it is, some services have already had to be reduced because there are not enough clinicians to provide them safely. Recruiting and keeping clinical staff in London is always a challenge and if we do not offer the best places to work, and the best places to train, we will not attract the best staff. Equally, if there are not enough senior staff, trainee doctors can't be supervised and are withdrawn from the hospital. All this means patients will not get the best care, and services will be reduced.

While this may sound alarming, it is worth noting that many clinicians working for the NHS in NW London feel that we have not explained in strong enough terms what would happen if we did nothing. Though services are mostly providing good standards of care at the moment, they cannot do so for much longer and it will be patients, and the clinicians who treat them and care for them, who will be the first to feel the consequences.

1

Do you agree or disagree that there are convincing reasons to change the way we deliver healthcare in NW London?

2

What comments, if any, do you have on any of the issues raised in sections 1, 2 or 3 of this consultation document?

4. So what is the answer?

Those of us leading the NHS in NW London – its leading GPs, hospital doctors, nurses, pharmacists and others – do not believe that things should just be allowed to deteriorate.

We do not believe that allowing unplanned cuts to services is the best way to manage the NHS either now, or in the future. It would be highly irresponsible not to act in these circumstances.

So, we have developed a vision for how we want health services to be developed and improved. Importantly, we have involved patient groups and representatives in developing this vision. In this consultation we want to find out what you think.

We have based this vision of care on improvements and innovations which are already being made in many parts of NW London and the rest of the country. This is important because it means the changes are tried or tested ways of delivering healthcare – we already know that they work, that they improve care and that they can be delivered.

Example **Stroke services**

London has made giant strides in tackling one of the biggest killers – stroke – over the last few years. Just three years ago, stroke care was spread across the city, with all 31 acute hospitals trying to deliver it.

Now, a dedicated network of eight hyper-acute stroke units provide the immediate, specialist care that stroke patients need – in NW London these include Northwick Park Hospital and Charing Cross Hospital – and another 24 stroke support units around London provide ongoing care once a patient is stabilised.

This is estimated to have prevented around 400 deaths in London and 100 in NW London every year since the changes were made and proves an important principle – that hospital care for certain conditions is much better when centralised at a specific, limited number of specialist sites.

There was of course some opposition to this change when it was suggested as it meant that some hospitals 'lost' services. However, it is now clear that it is much more important that an ill patient gets to the best place which has the right, expert consultants and surgeons, even if it means driving straight past their nearest hospital.

Example **Integrated care pilot**

A major frustration of patients with long-term conditions is that their care is not well managed across different NHS organisations. So an integrated care pilot (ICP) was set up in Westminster, Kensington and Chelsea, Hammersmith and Fulham, and in parts of Ealing and Hounslow to look into this, concentrating on people aged over 75, or with diabetes.

The ICP makes sure hospitals, community-care services, social care and local authorities all work as a team, so patients receive co-ordinated care across different services. It has proved so successful that it has won national awards for its pioneering work.

The ICP shows what can be done outside hospitals, particularly when the various health and social care teams in a community pull together for the benefit of the patient. It is now being expanded to include all boroughs in NW London and to include more conditions.

The GP practices taking part in the pilot have so far reduced emergency admissions to hospital for elderly people by 7% and have created 20,000 individual care plans for their patients.

5. Our vision for healthcare in NW London

So we can make sure that health services do not deteriorate severely in the future, we have a vision that in NW London you will have:

- the support you need to take better care of yourself;
- a better understanding of where, when and how you can be treated;
- the tools and support you need to better manage your own medical conditions;
- easy access to primary care providers, such as GPs, 24 hours a day, seven days a week; by phone, email or in person – when you need to be seen urgently
- fast and well-co-ordinated access to specialists, community and social care providers, (this access will be managed by GPs); and
- properly maintained and up-to-date hospital facilities with highly trained specialists available all the time.

There are three major principles that sum up our vision for the NHS in NW London. They are:

- localising routine medical care (delivering as much care as possible, as soon as possible, in convenient places which are easy to access);
- centralising the most specialist services (bringing more services together on a number of specific sites); and
- integrating care between primary, secondary and social care providers (making sure all parts of the NHS and social services work more closely together).

Our vision of care

Three main principles form our vision for care	
1	**Localising** Localising routine medical services means better access closer to home and improved patient experience
2	**Centralising** Centralising most specialist services means better clinical outcomes and safer services for patients
3	**Integrated** Where possible, care should be integrated between primary and secondary care, with involvement from social care, to give patients a co-ordinated service

3

Please say how important you think it is that we should aim to make sure that you and everyone else in NW London will have each of the following:

a) The support you need to take better care of yourself

b) A better understanding of where, when and how you can be treated

c) The tools and support you need to better manage your own medical conditions

d) Easy access to primary care providers, such as GPs, 24 hours a day, seven days a week; by phone, email or in person – when you need to be seen urgently

e) Fast and well-co-ordinated access to specialists, community and social care providers (this access will be managed by GPs)

f) Properly maintained and up-to-date hospital facilities with highly trained specialists available all the time

6. World-class healthcare outside of hospital

The vision for care outside of hospital developed by the NHS and particularly our local GP leaders is based on the principles of localisation and integration (see section 5).

Care outside hospital includes all those services provided in community settings such as in your home by community nurses, at your GP's surgery and in health centres. It also includes all the ways that you can look after yourself better.

This means delivering as much care as possible which is local to you at a convenient time – so either in your home or at your GP's surgery, for example, or even in your local hospital. By offering a much wider range of high-quality services within the community, we can make sure people have easier and earlier access to care.

Your GP practice will be at the heart of delivering an integrated service, using a range of providers. With more co-ordinated primary health and social care services, your GP practice will co-ordinate care across all services and have overall responsibility for your health. GPs and other primary-care professionals will be able to pick up on health issues at an earlier stage, and provide treatment that prevents patients ending up in hospital. This kind of planned care avoids the need for emergency and urgent care at a later stage. This approach, with different providers delivering care in an integrated package, will help people get better more quickly so they can get on with their lives.

To make sure that the quality of care improves, every care provider will have to keep to high standards of care. The new clinical commissioning groups, the organisations that are being led by GPs to plan healthcare services, will work with partners including health and well-being boards to make sure the standards are kept to.

The leaders of all the eight clinical commissioning groups in NW London have made the same commitment to change how primary and community care is delivered, based on four main quality standards.

Quality standards for care outside hospital (please see note below)

Individual Empowerment and Self-Care	Individuals will be provided with up-to-date, evidence-based and accessible information to support them in taking personal responsibility when making decisions about their own health, care and wellbeing.
Access, Convenience and Responsiveness	Out-of-hospital care operates as a seven day a week service. Community health and care services will be accessible, understandable, effective and tailored to meet local needs. Service access arrangements will include face-to-face, telephone, email, SMS texting and video consultation.
Care Planning and Multi-Disciplinary Care Delivery	Individuals using community health and care will experience co-ordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. Effective care planning and preventative care will anticipate and avoid deterioration of conditions.
Information and Communication	With an individual's consent, relevant parts of their health and social care record will be shared between care providers. Monitoring will identify any changing needs so that care plans can be reviewed and updated by agreement. By 2015, all patients will have online access to their health records.

Note: Plain English Campaign's Crystal Mark does not apply to these standards as they were agreed by the leaders of the eight clinical commissioning groups in NW London before this consultation document was written.

Delivering this vision will:

- improve access to GPs and to other services so patients can be seen more quickly and at a time that is convenient to them;
- mean more people can take control of their own health conditions;
- help carers to support those with health and social care needs;
- mean that healthcare providers and patients will be able to access information about patients' health, so reducing possible errors and avoiding patients having to give the same information many times;
- deliver co-ordinated care plans for people, preventing deterioration in health and reducing admissions to hospital; and
- reduce complications and poor outcomes for people with long-term conditions by providing more specialist services in the community.

4a

How far do you support or oppose the standards that have been agreed for care outside hospital?

7. Making hospitals centres of excellence

Our vision for hospital care is based on centralising services – that is, bringing more services together on fewer sites to create a greater level of expertise so that we can provide better care and save more lives.

It has been shown that having more expertise and more senior doctors available in hospitals improves the outcome for patients. As shown in section 4, we know that this approach works, based on what has been done to centralise heart-attack care, major arterial surgery, stroke care and trauma care in London. Other countries around the world have used exactly the same approach successfully.

In NW London however, as explained in section 2, not enough services have been centralised, leaving some hospitals with stretched senior medical cover and not enough expertise – particularly at the weekends and at night. Across NW London, the quality of hospital care differs too much. It sometimes meets high standards, but quite often it does not and this can, in the worst cases, lead to unnecessary deaths.

Clinicians have looked closely at this and at the latest research and evidence and believe it is clear that by centralising certain services, patients will have better outcomes. This may mean reducing recovery time, preventing relapse or the need to go back to hospital or, in the most extreme cases, saving lives.

Naturally, people may be concerned about travel times. It is important that we can still provide emergency care close to, or at, the scene of an accident. However, once someone is being treated by an ambulance crew, the time it takes to get to hospital is much less important. These days so much more care can be provided at the scene of accidents, actually within ambulances, or in the community. And, of course, ambulances do not station themselves at hospitals, but at more spread-out locations to provide the best cover for a certain area.

Outcomes for patients improve much more if they are taken to the right place for treatment even if this is not the place nearest to where they were taken ill. This is already happening in some situations and is getting excellent results. For example, in a major accident that happened anywhere in NW London, the ambulance crew would stabilise the patient and then take the patient straight to the best hospital to treat their injuries, even if it meant driving past several hospitals on the way.

The big difference that centralising services makes is that it means we can provide access to senior doctors and lots of back-up services 24 hours a day, seven days a week. Travel times need to be within an acceptable limit, but are not as critical as they used to be

in deciding exactly where services such as emergency care should be located.

Centralising services onto fewer, more specialist sites also has important benefits for training clinicians. Academic and training institutions, such as medical specialties, work best when they are located closer together. Sharing ideas, innovations, new technology and new techniques becomes much easier. This is why the most successful health education and research institutions all over the world, as in London, are often 'clustered' together around a well-known campus or area.

NW London has some excellent centres of academic and medical institutions already – such as the Academic Health Science Centre, covering Imperial College and Imperial College Hospital Trust in West London, and the specialist services in Chelsea and Westminster Hospital which cover heart, lung and cancer services. Making sure we build on this excellence is important to us. We want to make sure we not only have a current, highly skilled workforce which is able to deliver the best services, but that we can protect that workforce for future generations.

To make sure that the quality of care is improved, every provider will have to meet high clinical standards of care. The local GP commissioners will monitor this. All hospitals in NW London will have to meet these standards, which we have agreed.

Quality standards for hospital care (please see note 1 below)

Emergency Surgery and A&E	**Access to senior and specialist skills**	• All emergency admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital • Acute medicine inpatients should be seen twice daily by a relevant consultant • When on-take for emergency / acute medicine and surgery, a consultant and their team are to be completely freed from any other clinical duties / elective commitments that would prevent them from being immediately available • Any surgery conducted at night should meet NCEPOD (National Confidential Enquiry into Patient Outcome and Death) requirements and be under the direct supervision of a consultant surgeon • All hospitals admitting emergency general surgery patients should have access to an emergency theatre immediately and aspire to have an appropriately trained consultant surgeon on site within 30 minutes at any time of the day or night • The Critical Care Unit should have dedicated medical cover present in the facility 24 hours per day, seven days per week
	Access to diagnostics and multi-professional teams	• All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g. interventional radiology) in a timely manner 24 hours a day, seven days a week, to support decision making • Prompt screening of all complex needs inpatients should take place by a multi-professional team which has access to pharmacy, psychiatric liaison services and therapy services (including physiotherapy and occupational therapy, seven days a week with an overnight rota for respiratory physiotherapy) • Single call access for mental health referrals should be available 24/7 with an aspired maximum response time of 30 minutes
	Processes	• The majority of emergency general surgery should be done on planned emergency lists on the day that the surgery was originally planned and any surgery delays should be clearly recorded • On a site without 24/7 emergency general surgery cover, patients must be transferred, following a clear management process, to an Emergency Surgery site if a surgical emergency is suspected without delay

Maternity	• Women with complex medical conditions must be offered assessment by a consultant obstetrician • Units with more than 6000 births a year should provide 168 hours of consultant presence (24/7) • Units with between 2500 and 6000 births a year or classed as high risk should provide 98 hours a week of consultant presence (please see note 2 below) • Units with up to 2500 births a year are strongly recommended to have 40 hours of consultant obstetric presence but should conduct a risk assessment exercise to determine their individual requirements • Outside the recommended minimum 40 hours of consultant obstetrician presence, the consultant will conduct a physical ward round as appropriate at least twice a day during Saturdays, Sundays and bank holidays, with a physical round every evening, reviewing midwifery-led cases following referral • All women's care should be co-ordinated by a named midwife throughout pregnancy, birth and the postnatal period. Where specialist care is needed this should be facilitated by her named midwife. Clinical responsibility for women with complex care needs should remain with the specialist, but these women should still receive midwife-co-ordinated care • Consultant-delivered obstetric services should include a co-located midwife-led unit to provide best care and choice for women and babies. Women should be able to choose the option of an out of hospital pathway (home birth and standalone midwife-led unit) if appropriate • Obstetric units will need support from different services, including onsite access to emergency surgery (some have argued this can be provided by emergency gynaecological surgery cover), interventional radiology, and critical care, in addition to support from an onsite neonatal inpatient unit but not necessarily paediatrics • There must be 24-hour availability in obstetric units of a clinical worker fully trained in neonatal resuscitation and stabilisation of a new born baby for immediate advice and urgent attendance • Midwifery staffing levels are calculated and implemented according to birth setting and case mix categories to provide a one-to-one midwife-to-woman standard ratio during active labour with immediate effect • There must be access to emergency theatre when required
Paediatrics	• All paediatric inpatient admissions to be seen and assessed by a relevant consultant within 12 hours of the decision to admit or within 14 hours of the time of arrival at the hospital • When on-take for emergency and acute paediatric medicine and surgery, a consultant and their team are to be completely freed from any other clinical duties or elective commitments that would prevent them from being immediately available • All inpatient paediatric services units need to have paediatric consultant availability within 30 minutes • Paediatric inpatients should be seen twice daily by a paediatric consultant • Paediatric Assessment Units (PAUs) should have clearly defined responsibilities, with clear pathways, and should be appropriately staffed to deliver high quality care as locally as possible

Note 1: Plain English Campaign's Crystal Mark does not apply to these standards as they were agreed by our clinical leaders before this consultation document was written.

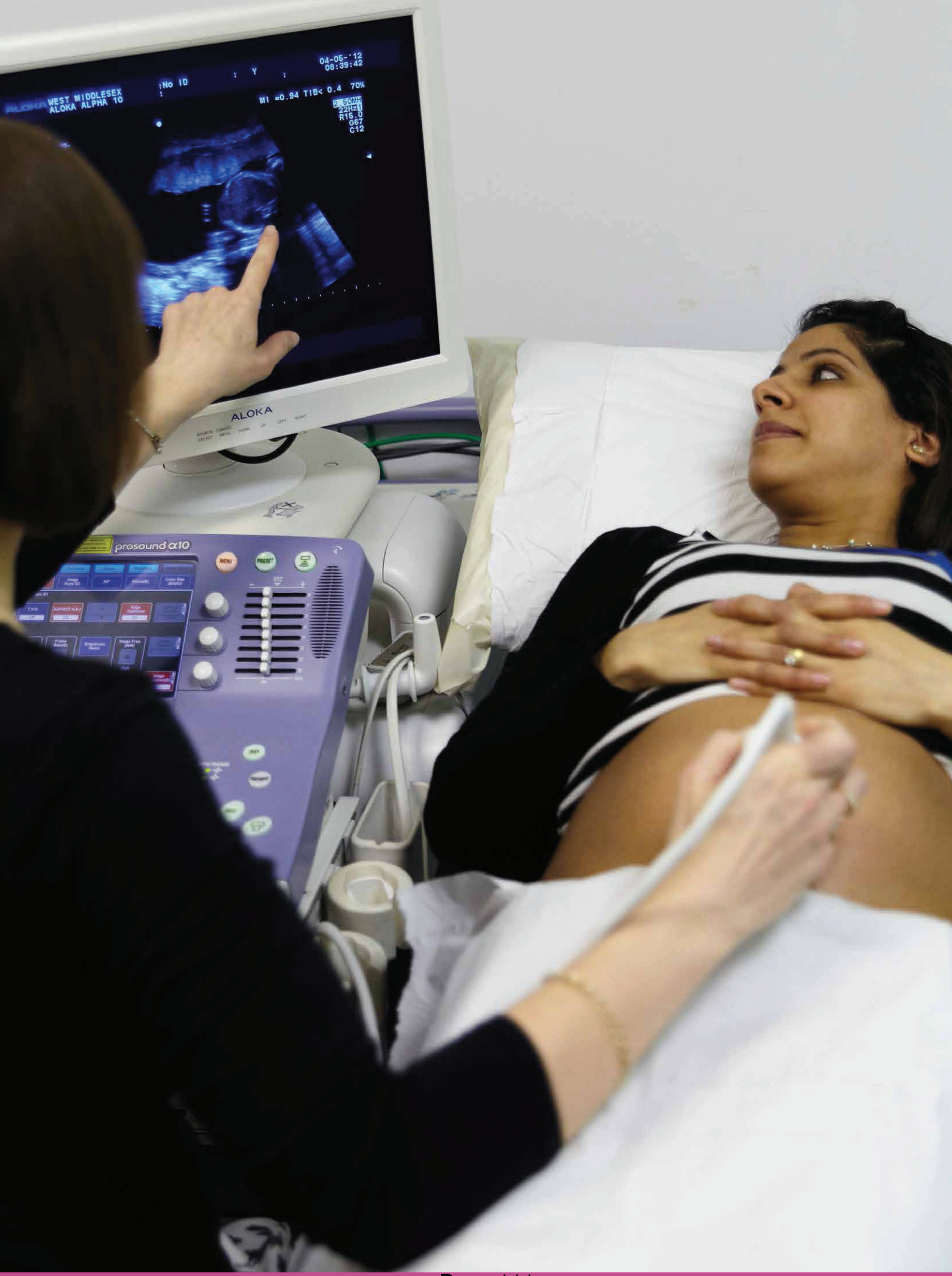
Note 2: Royal College guidance says that units with over 5000 births a year should provide 168 hours of consultant presence. Over time local maternity units in NW London will move to meet this standard.

Delivering this vision will:

- save lives by providing better access to more senior doctors for more of the time;
- mean that people will be treated more quickly by more senior doctors, leading to fewer complications; and
- allow doctors to develop their specialist skills, so they can provide the best possible specialist care.

4b

How far do you support or oppose the standards that have been agreed for care in hospital?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8. What will our vision mean for you?

A main part of this vision is that all the different parts of the NHS system will work together much more closely and effectively – whether they are hospitals, GP practices, community providers, or local authorities providing social services.

It will mean all these organisations, their leaders and workforces working across boundaries and without barriers, and as a result, patients in NW London all receiving better care.

In short, the vision will mean:

- 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 prefer;
- you can easily see a GP or community-care provider 24 hours a day, seven days a week by phone, email, or face-to-face in local, convenient facilities;
- you will be able to see a specialist or receive support from community or social care services if necessary (this will be organised quickly and GPs will be responsible for co-ordinating your healthcare); and
- if you need to go into hospital, it will be a properly maintained and up-to-date hospital where you receive care from highly trained specialists, available seven days a week, who have the specific skills needed to treat you.

The following stories show how care will improve for typical NW London patients before and after the proposed changes are put in place.

5

Do you agree or disagree that some services which are currently delivered in hospital could be delivered more locally?

6

How far do you support or oppose the idea of bringing more healthcare services together on fewer sites?

7

What further comments, if any, do you have on any of the issues raised in sections 4, 5, 6, 7 or 8 of this consultation document? (For example, if you disagree with our proposals, why is that?)

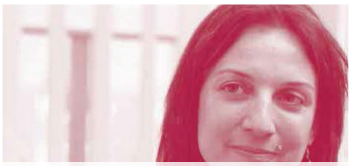
Easy access to high-quality care

Melanie is 36. She is a working mother with a young daughter who has a fever.

Now
- Melanie rings her GP but cannot get through, and takes Maya to A&E.
- The traffic is heavy and after a stressful journey they finally arrive. Maya is quickly assessed but not classed as high risk.
- After three hours they finally see a doctor who diagnoses that Maya is teething.

Future
- Melanie rings 111 and is given advice and an appointment for that evening at a local practice with extended hours, or a primary care centre by GP's out-of-hours service.

Simpler planned care pathways



Maria is 48. She has made an urgent appointment with her GP after bleeding vaginally for the last two days.

Now
- Maria sees her GP, who is not sure of the best treatment options and refers her to an outpatient clinic.
- Maria has an appointment and is scheduled for a follow-up appointment which takes several weeks to arrange.
- The results are not sent to her GP.

Future
- Maria sees her GP who books her for a one-stop assessment and diagnosis on-site.
- Two hours later the GP checks on the results and phones a consultant for a specialist opinion and together they agree on an appropriate procedure.

Quick responses to urgent health problems

Archie is 80. A family member has taken him to the doctor as he is in some pain and having difficulty passing urine.

Now
- The GP has diagnosed Archie as having a urinary tract infection. He is given a course of oral antibiotics and sent home.
- The next day his son visits and finds Archie in a confused state. Unsure what to do, he takes Archie to A&E.
- The strange surroundings make Archie more confused and he is admitted.
- Three weeks later, Archie is still in hospital and his mental state has deteriorated.

Future
- The GP has left a contact number for the rapid response service, following his appointment.
- Archie's son visits and finds Archie in a confused state and rings the rapid response helpline.
- A GP, social worker and physiotherapist from the rapid response team arrive and assess Archie at home, authorising a seven-day package of care to stabilise him at home.

Co-ordinated care for people with a long-term condition

Sameera is 45. She sees her GP complaining of shortness of breath and tightness in her chest.

Now
- After visiting her GP, Sameera is diagnosed with chronic obstructive pulmonary disorder, is put on an inhaler and given a stronger dose of drugs.
- Sameera continues to struggle at home with her condition and after a series of complications is admitted to A&E.

Future
- Sameera's GP thinks she needs an integrated care plan and he raises this at a case conference with a specialist chest doctor.
- They identify that Sameera needs advice on how to use her inhaler properly, rather than a stronger dose of drugs.

Less time spent in hospital

David is 80. He has recently fallen, fractured his hip and been admitted to hospital.

Now
- Following treatment, David's hip is mending well so the duty doctor reviews his case and says he is fit to leave following a physiotherapist's review.
- The review happens on a Friday and physiotherapists are not available until Monday, leaving David in hospital over the weekend.
- Social care takes three weeks to organise a package of care for when David leaves hospital.

Future
- When David is admitted to hospital his history is available to staff.
- His health and social care co-ordinator is told and plans to discharge him begin immediately.
- The next steps are recorded in a clear care plan and everything is in place for when the time comes for David to leave hospital.

9. Delivering the vision

If we are to deliver this new vision for health services across NW London, a lot needs to be done, and major changes need to be made to the way the NHS currently works.

Of course this will not be easy, nor will it be very popular among certain groups of people or communities. People understandably get very attached to local hospitals, whether they live nearby, have been treated there, or work there.

But that does not mean it is wrong to change services – healthcare is constantly changing, as are the ways it is delivered, where it is delivered from, and who delivers it. So while people feel strongly about local health services, this does not mean it is wrong to change the services. But it does mean we should make these changes thoughtfully, carefully, and by consulting patients – and many of you reading this document – first.

Changes, above all, must lead to improvements in the quality of care and so it is important that GPs, hospital clinicians, nurses, community service staff and others lead the way in how these changes are designed and put in place. Clinicians need to work with patients and patient groups and senior managers to make sure that proposals are good for patients as well as being realistic.

Delivering this vision will also significantly improve the finances of the NHS in NW London. It will take at least three years to deliver this vision and lots of work has been done to make sure the NHS can afford it. Delivering the vision for care outside hospitals will cost up to £120 million. On top of this, it is estimated that it will cost between £60 million and £90 million to run new and old services at the same time while changes are made. However, once made, the changes will mean that hospitals in NW London will be in a much improved financial position than if we do nothing. The pre-consultation business case (volume 1, chapter 6) available on our website at www.healthiernorthwestlondon.nhs.uk contains more detail on this financial analysis.

In the rest of this document, we describe:

- which services will be delivered where;
- how we will deliver the vision for services outside hospital;
- what services will be delivered in which type of hospital;
- how many hospitals we believe we need in NW London;
- the process we have used to recommend where these hospitals will be; and
- three different options for where these hospitals should be.


Angie Waddell

10. Where will care be provided in future under the proposals?

We have looked at the way in which we deliver healthcare, particularly the settings where we can deliver it, and have identified eight different settings for care.

Home – some services can be provided in people's homes, for example through nursing care or telephone support services.

GP practice – GP practices can provide lots of services other than GP appointments, such as immunisations, screening, blood tests and therapy services.

Care network – there are some services that can be provided by GP practices but we need practices to group together so there are enough patients to make it cost-effective to provide the skilled workforce and specialist equipment needed. This includes some diagnostic tests (such as ECGs) and therapies, and services for some long-term conditions. Grouping practices together can also mean urgent cases can be seen within four hours.

Health centre – sometimes a building is needed to provide 'networked' GP services such as therapy, rehabilitation or specialist imaging equipment.

Local hospital – this type of hospital provides all the most common things people need hospitals for, such as less severe injuries and less severe urgent care, non-life threatening illnesses, care for most long-term conditions such as diabetes and asthma, and diagnostic services. It basically provides the kinds of services that most people going to hospital in NW London currently go there for.

Major hospital – this is the closest to what is currently known as an 'acute' or district general hospital, and provides most types of care, right up to highly complex and urgent services. Major hospitals also provide care for children and maternity services, since these both sometimes need complex emergency services. In these proposals these hospitals will have more senior clinicians and specialist services than now – they will have investment so that they can be better than our current 'acute' hospitals. If patients at a local hospital suddenly need more urgent or complex care, they will be transferred by ambulance to these major hospitals. Major hospitals will also provide local hospital services.

Elective hospital – this hospital is where you go if you need an operation which is not urgent, so it could be

planned (or 'elected') by you or your doctor to happen when necessary. These hospitals cover things like hip replacements and cataract operations. They are particularly good places to be treated because they are not disrupted by emergency cases which have to be dealt with before less urgent ones, and can more easily be kept clean and free from hospital infections.

Specialist hospital – this is where clinicians have specialised in treating certain conditions, for example cancer or heart conditions or lung diseases. So you only tend to go to these places if you have a condition which needs really specialist care, perhaps because your condition is particularly life-threatening or complex.

The names of these eight settings of care and the services associated with them have been determined by clinicians and commissioners in NW London. However, we recognise there is a confusing array of different titles in use across London and nationally. The Department of Health is currently undertaking a piece of work on urgent and emergency care to support a more consistent approach across the country. Once the work is published, we will make sure that our proposals are aligned with the Department's recommendations.

8

We have described the proposals to deliver different forms of care in different settings. How far do you support or oppose these proposals?

9

What further comments, if any, do you have on any of the issues raised in sections 9 or 10 of this consultation document? (For example, do you have any concerns about arranging care in this way, or about the way we propose to classify hospitals? Can you suggest a better way of delivering care?)

Home

- GP, community and social care services
- Patient rings 111 for advice
- Response within four hours

GP practice

- GP consultations
- Management of long-term conditions
- Health promotion and preventative services

Care network

- Multi-disciplinary care
- Diagnostic and therapy services

Health centre

- GP, therapy and rehabilitation and diagnostic services
- Specialist GP services

Local hospital

- Urgent care centres
- Outpatients and diagnostics
- Further services including
  – specialist clinics
  – outpatient rehabilitation

Major hospital

- A&E, urgent care centres and trauma care
- Emergency surgery and intensive care
- Obstetrics and midwifery unit
- Inpatient paediatrics

Elective hospital

- Elective surgery and medicine
- Outpatients and diagnostics
- High-dependency care

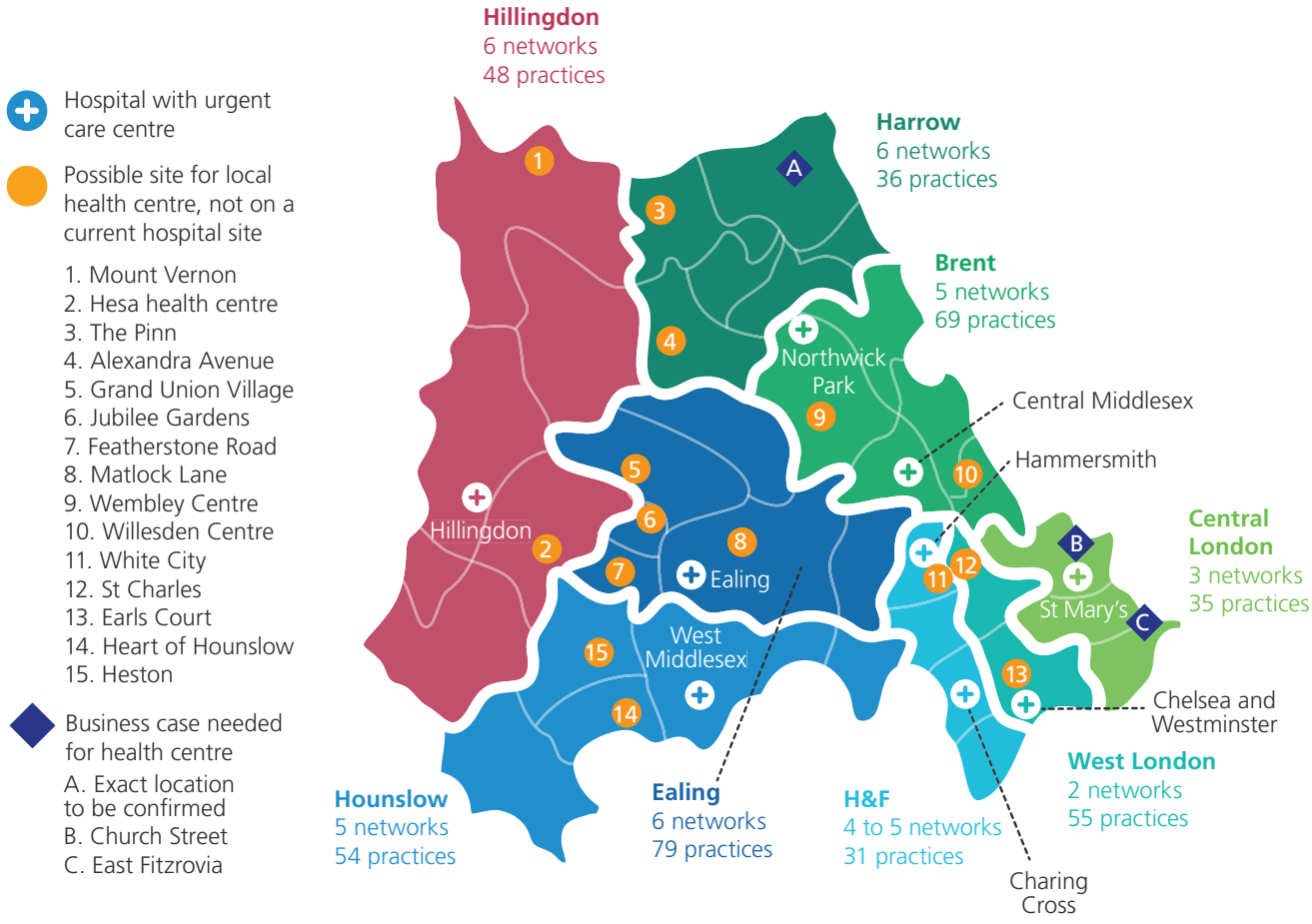
Specialist hospital

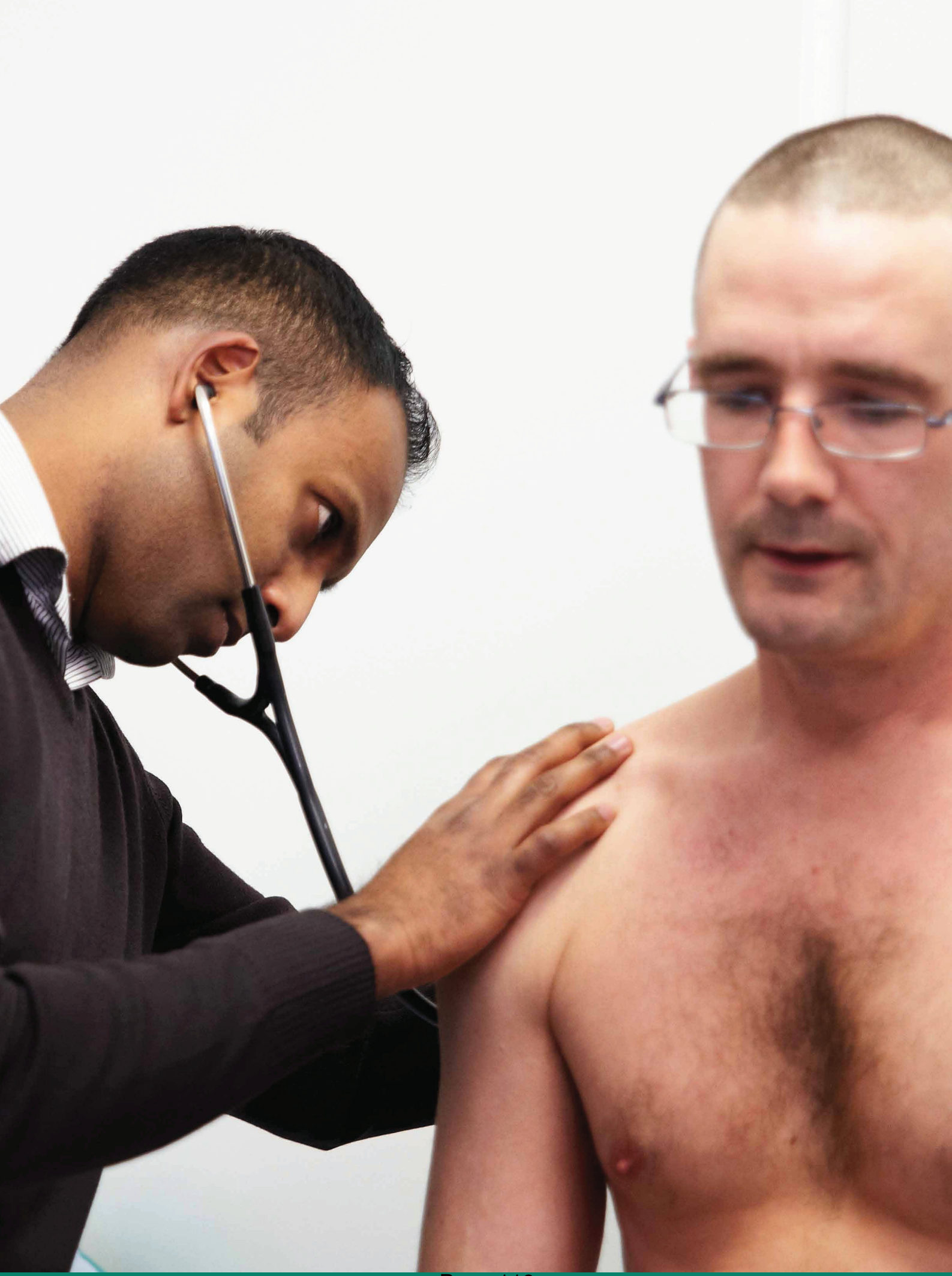
- Highly specialised care such as cardiothoracics and cancer

11. Proposals for delivering care outside hospitals

To deliver the vision for care outside hospitals, GP practices will work together to serve their patients, making the best use of their skills and resources to improve access and quality.

Networks of GP practices will work with other health and social care providers to deliver co-ordinated services to the local community, improving care planning and local services and information and communication standards. We have developed plans showing where services will be provided.





Within the home, GP surgeries, networks and health centres, we will deliver:

- **easy access to high-quality care**, with longer opening hours for GPs, and urgent care centres open 24 hours a day, seven days a week (these centres will see many of the people who would currently go to A&E);
- **simpler planned care pathways** (the different stages of NHS care you may go through), with specialists available to give advice, more clinics in the community for common health issues and patients able to have simple operations without needing to go to hospital;
- **quick responses to urgent health problems**, by setting up services in each borough to prevent 16,000 patients from having to go to hospital each year;
- **co-ordinated care for people with a long-term condition**, by setting up 38 multi-disciplinary health and social care teams covering the whole of NW London (this will mean people with a long-term condition will have a personal care plan); and
- **less time spent in hospital** because care providers will know when someone is in hospital and will make sure services are in place for them to leave hospital as soon as they can.

Up to £120 million will be invested in these services over the next three years, paid for out of savings made from working differently, to make sure that we can care for people outside hospital. We have promised that services will be in place before changes are made to hospital-based services.

There will need to be between 750 and 900 extra staff to run these new services. Many of these staff are already working in NW London, although they may have to work differently in the future. The full pre-consultation business case (volume 2, chapter 7) on our website, www.healthiernorthwestlondon.nhs.uk sets out the plans for developing the workforce in more detail. There will also need to be an extra 130 to 140 beds in the community.

GP leaders in NW London have agreed detailed plans for every borough to cover these new services. Because the people who live in each borough are different, services in each borough will be different. You can find more details of each borough plan for health services outside hospital on our website at www.healthiernorthwestlondon.nhs.uk

10

How far do you support or oppose our plans to improve the range of services we deliver outside hospital?

11

What further comments, if any, do you have on any of the issues raised in section 11 of this consultation document? (For example, what comments do you have on our plans to improve the range of services we deliver outside hospital?)

Investment in services outside hospital

Theme	From…	To…	Quality	Reduction in hospital activity	Investment (see note below)
A Easy access to high-quality care	• 9 urgent care centres (various opening hours) • 7 A&E departments • 2 limited A&E departments • Significant difference in GP practice opening times	• 9 urgent care centres (24 hours a day, 7 days a week) • 5 A&E departments • Extended GP opening hours for every patient	• More reliable emergency care • Better access to GP practices	• 100,000 hospital stays (14%) • Gross £12m to £15m	• 30 to 35 extra staff • £5m to £7m
B Simpler planned care pathways	• Most patients get access to specialist opinions through outpatient departments • Difference in referrals by GPs to outpatients • Most minor procedures only available in hospitals	• Access to specialist opinion by phone for GPs while with patient • Clinics in community for common specialties • Referrals within clear guidelines and reviewed by other GPs • Patients able to quickly have minor elective procedures without going to hospital	• Patients able to access a greater range of services through their GP • Less waiting times • More convenience	• 600,000 outpatient appointments (22%) • Gross £83m to £95m • 10,000 hospital stays (14%) • Gross £20m to £24m	• 205 to 235 extra staff • £59m to £65m
C Quick responses to urgent health problems	• Rapid response service in Brent avoiding around 1,000 admissions each year	• Rapid response service across all of NW London avoiding 16,000 hospital admissions each year	• Patients avoid unnecessary hospital visits	• 29,000 avoided emergency admissions (10%) • 391 acute beds • Gross £47m to £54m	• 275 to 320 extra staff • 130 to 140 community beds • £29m to £34m
D Co-ordinated care for people with a long-term condition	• Care networks have been piloted for integrated care for diabetes and the elderly for a population of 500,000	• Around 38 multi-disciplinary groups across NW London, covering 1.9 million people with care plans for all long-term conditions and elderly and case conferences for complicated cases	• 17,000 more diabetics • 200 fewer amputations • 880 fewer deaths	• 19,000 avoided emergency admissions (7%) • Gross £33m to £39m	• 255 to 300 extra staff • £27m to £32m
E Less time spent in hospital	• Many patients stay in hospital longer than necessary and leave without good support	• Care providers will know when a patient is in hospital and will help them into planned, supportive care outside hospital	• Better recovery with support when the patient leaves hospital	• Activity-reduction included under D (above)	• Included in trust cost improvement programmes

Source: Commissioning Service Plan, 1st December 2011, QIPP plans 15th December 2011, QIPP revision, Healthcare for London; HES; CCG input and expert interviews; NHS DSU; CCG finance teams;

Note: Not all out-of-hospital investment figures are listed. Total investment includes staffing, equipment and other services, including services provided by charitable or voluntary organisations.

Total investment £120m to £138m

12. Our recommendations for local hospitals across NW London

Most care that is currently delivered in hospitals will still be delivered locally in a local hospital, under changes proposed by 'Shaping a healthier future'.

The local hospitals in our plans will have specialist staff (who may also work in a major hospital) and specialist equipment and will be open 24 hours a day, seven days a week to see people with urgent health problems. Specialist staff will work with GPs and other community clinicians to deliver personalised healthcare. GP services, community services and social care will be based in these local hospitals, bringing services together around your needs.

Local hospitals will also be part of the local community. This means local patients, patient groups, the voluntary sector, the local council including the health and well-being board, and local clinicians will be involved in developing and running them. They will offer services based on what is needed locally, so these might be different in each local hospital.

The local hospital will also act as a 'home' for local clinicians – a place for education and training, for continuing professional development, as a centre for research and for clinicians and other professionals to come together to review and improve patient care.

Local hospitals will offer slightly different services depending on the health needs of the different local communities across NW London, but these services will include, for example, the following:

- **Quicker and more co-ordinated healthcare**. The local hospital will provide specialist care for people with long-term conditions. Patients and carers will be able to come together in self-care and support groups, either at the local hospital or closer to home. Some GP practices, community services and social services may be based in the local hospital, and will make sure care is co-ordinated for individual patients.

- **Access to specialist skills**. In some cases, patients may need specialist appointments. Many of these appointments will be available in local hospitals, including for people who are going to have, or have had, an operation. Some patients, for example, those with Parkinson's disease or children who need insulin for diabetes, need a lifetime of specialist care, much of which will be available at the local hospital. Also, some local hospitals will be able to provide treatments such as medical oncology, renal dialysis and simple surgery.

- **Tests**. Clinicians sometimes need tests so they can find out what is wrong with a patient or understand whether a treatment is working. Tests such as x-ray, ultrasound, endoscopy or MRI scans will be available in some local hospitals.

- **Bringing services together**. The local hospital will bring services together for patients. This could include assessments, transport to and from home and pain-management services. This will make it easier for patients to get to services and for clinicians to find out what is wrong with the patient and treat them.

- **Better nursing, therapy and rehabilitation services**. Local hospitals will offer better nursing, therapy, rehabilitation and community services such as physiotherapy, well-baby clinics, chiropody and wound clinics. This will include appointments with specialists. It might also include beds for patients who are at risk of deteriorating, and beds for patients who have been to a major hospital but who no longer need specialist care and can be cared for nearer to their home.

Urgent care centres

Local hospitals will have an urgent care centre, open 24 hours a day, seven days a week. Urgent care centres specialise in treating patients with urgent illnesses and injuries and conditions that can be seen and treated without the patient having to stay in hospital.

Clinicians in urgent care centres will also be skilled in stabilising patients who need to be transferred to more specialist A&E centres. There will be special processes to make sure these transfers happen quickly and some urgent care centres may also have beds where patients can be admitted if their problem can be dealt with locally.

NW London has led the way with some of the most successful urgent care centres in London. The centres are staffed by GPs and nurse practitioners. Many of these urgent care centres are inside A&E departments and are already treating a wide range of patients. People who go there get a very high quality of care. Patient satisfaction is high and waiting times are low. Today, there are different 'models' of urgent care centres in NW London and the proposed changes would encourage higher standards of urgent care centres across the area. For example, urgent care centres in NW London currently have different opening times and treat different problems. This can be confusing for patients and we will make sure that, in future, all urgent care centres in NW London are open 24 hours a day, seven days a week and all have the same level of services.

We want all urgent care centres in NW London to:

- see and treat patients within four hours of them arriving;

- be led by primary-care clinicians such as GPs;

- be linked with other services such as the new non-emergency phone number for the NHS (111); and

- have access to tests and specialist clinicians.

The kinds of health problems all urgent care centres would be able to treat include:

- illnesses and injuries not likely to need a stay in hospital;

- x-rays and other tests;

- minor fractures (breaks);

- stitching wounds;

- draining abscesses that don't need a general anaesthetic; and

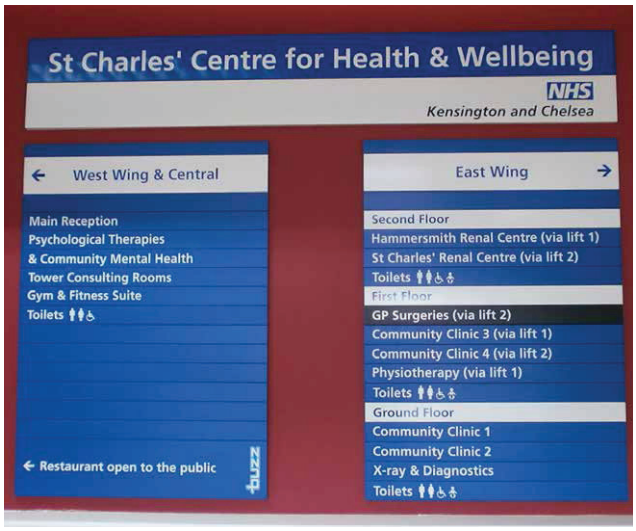
- minor ear, nose, throat and eye infections.

Urgent care centres will see people and children of any age.

It is important to note that urgent care centres do not treat problems such as major burns, head injuries, strokes, sickle-cell crisis, severe shortness of breath, heart failure, overdoses and self-harm. All these problems can be a sign of serious conditions that may need to be treated in a major hospital.

The best example in London of a local hospital is Queen Mary's Hospital in Roehampton, North East Wandsworth, which is described in the pre-consultation business case (volume 2, chapter 8) on our website at www.healthiernorthwestlondon.nhs.uk. St Charles' Centre for Health and Wellbeing in Ladbroke Grove in NW London also provides many local hospital services, including an urgent care centre. The patients who use these services rate them very highly and they are an important part of the local community.

The kinds of services we want to see provided in local hospitals are currently delivered at all nine acute hospitals in North West London (Charing Cross Hospital, Chelsea and Westminster Hospital, Central Middlesex Hospital, Ealing Hospital, Hammersmith Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital). Our proposals would see all these hospitals continuing to provide local hospital services, including an urgent care centre and outpatient and diagnostic services.



12

Do you agree or disagree that local hospital services such as urgent care centres (those open 24 hours a day, seven days a week) and outpatient appointments should continue to be provided at the nine acute hospitals in North West London that currently do so?

13

How far do you agree or disagree with our plans for urgent care centres?

14

What further comments, if any, do you have on any of the issues raised in section 12 of this consultation document? (For example, if you disagree with our proposals, what would you do differently?)

13. Elective hospitals using our high-quality buildings

If our proposals are agreed, elective hospitals would carry out operations on patients in NW London which are described as 'elective' rather than 'urgent' – such as hip replacements, and cataract operations.

In an elective hospital, treatment is not disrupted by emergency cases – which can take priority over less urgent ones at other types of hospital – and, partly because of this, they can more easily be kept clean and free from hospital infections.

Elective hospitals can be located within, or independently of, major hospitals as they do not rely on any of the back-up services of a major hospital. We are proposing that we should use any high-quality buildings that have spare space to house our elective hospitals. This would particularly include the buildings at West Middlesex Hospital and Central Middlesex Hospital, which have been built especially to deliver high-quality elective care.

Major hospitals would still continue to provide elective services and patients would still be able to choose where they had their operation.

15

How far do you support or oppose our recommendation that we should use our high quality hospital buildings with spare space as elective hospitals?

16

What further comments, if any, do you have on any of the issues raised in section 13 of this consultation document?

14. Five major hospitals for NW London

In developing a vision for hospital services, we focused on different areas: emergency surgery, A&E, maternity (pregnancy and birth), and paediatrics (children).

Doctors often need these specialised areas to be based in the same hospital to treat certain conditions.

Under our proposals, major hospitals would provide a full range of high-quality clinical services for patients with urgent or complicated needs (or both). They will have investment to equip and staff an A&E department (open 24 hours a day, seven days a week) with urgent surgery and medicine and a 'level 3' intensive care unit. Major hospitals would usually also provide consultant-led maternity services and radiology services. They may also have complicated surgery, a hyper-acute stroke unit (HASU), inpatient paediatrics (children), a heart attack centre and a major trauma centre.

In NW London each major hospital would also provide local hospital services, including an urgent care centre.

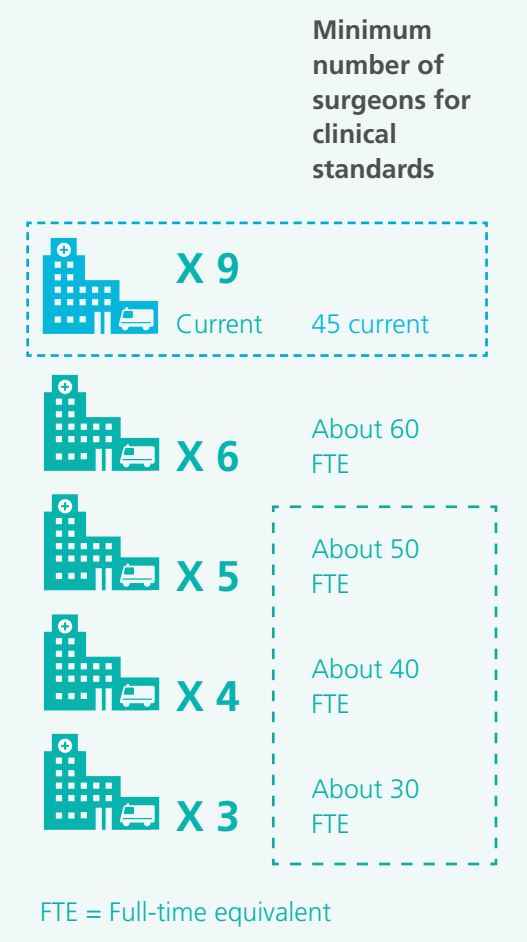
We looked at how many major hospitals we would need in NW London to deliver the highest-quality care. We used a set of 'hurdle criteria' (a series of tests) to help us decide. To pass these tests, we looked at how many major hospitals would be needed to:

- deliver the clinical standards shown in section 7;
- deliver them within a realistic time without affecting the high quality of services; and
- be financially affordable.

We looked at all the evidence and agreed the ideal number of major hospitals would be five. This is for the following reasons.

- Having six or more major hospitals would solve some of the problems we face in NW London as shown in section 2. But there would still be too many hospitals because we would not be able to recruit enough clinicians to provide services safely enough for six or more hospitals. We cannot solve this problem by hiring more clinicians because clinicians need experience of dealing regularly with complications to keep up their expertise – and there are not enough cases of certain complicated conditions to do this in NW London.

- A good example of this is the number of surgeons needed to provide the highest quality of emergency surgery. We know that having senior surgeons available at night and at the weekends means better health outcomes for patients. Today, there are only 45 surgeons working in NW London, but we would need at least 60 surgeons to meet the clinical standards at six hospitals.

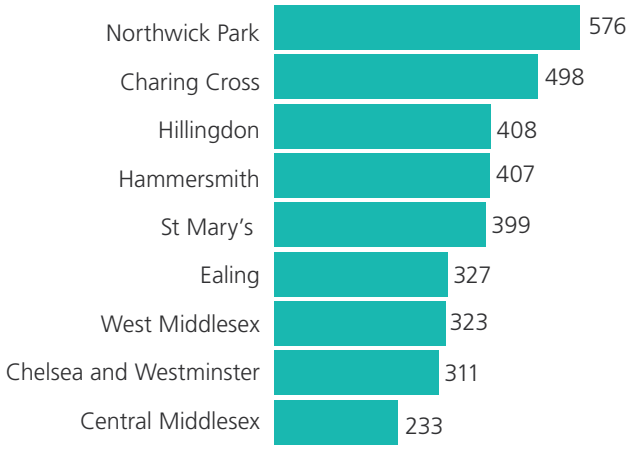


- To begin with, some clinicians recommended that we should have four or fewer major hospitals but it was agreed that this would not be enough. This is because we would have to build much bigger hospitals and move lots of services which would be high risk, difficult to deliver, and expensive. For example, if there were only three major hospitals in NW London, we would need to build hospitals that are twice the size of the ones we have now.

Number of beds needed for each major hospital if there are five or fewer hospitals in the area

Three major hospitals	**About 800 to 1000**
Four major hospitals	**About 600 to 700**
Five major hospitals	**About 500 to 600**

Current number of beds



We agreed that all A&E departments would need a maternity service as part of back-up services. And we agreed that maternity services need the back-up of a major or specialist hospital and so should not be put in other types of care settings (for example, local hospitals). We propose that all major hospitals will have a consultant-led maternity unit.

To give women in NW London more choice about where they give birth, the new major hospitals would also have a midwife-led maternity unit. We are not suggesting that we have any midwife-led units in NW London that are not within major hospitals. You can see the explanation for this in the pre-consultation business case (volume 2, chapter 8) which you can find on our website www.healthiernorthwestlondon.nhs.uk. All maternity services will work to support women who choose to have their baby at home.

Maternity services also need a paediatric (children's) service to provide support for new babies. So we propose that all major hospitals in NW London in future will have an inpatient paediatric service, unless there are enough specialist maternity services to support a paediatric consultant rota. The only hospital where this is possible in NW London currently is at Queen Charlotte's and Chelsea Hospital at Hammersmith Hospital. We propose that we should keep the consultant-led maternity unit at Queen Charlotte's and Chelsea Hospital. This means there would be six consultant-led maternity units in NW London if Hammersmith Hospital were not classed as a major hospital.

17

How far do you support or oppose the recommendation that there should be five major hospitals in North West London?

18

How far do you support or oppose the recommendation that all major hospitals should have inpatient paediatric (children's) units?

19

How far do you support or oppose the recommendation that all major hospitals in North West London should have consultant-led maternity units, with an extra consultant-led maternity unit at Queen Charlotte's and Chelsea Hospital if Hammersmith Hospital is not a major hospital?

20

What further comments, if any, do you have on any of the issues raised in section 14 of this consultation document? (For example, if you oppose the recommendations, how many major hospitals do you think there should be in North West London? Why do you think that?)

15. Where should the major hospitals be located?

We recommended that NW London should have five major hospitals and then carried out an in-depth evaluation to look at where these major hospitals should be.

Patients and clinicians told us that being able to access services easily was very important. So, to help them think about where to put the major hospitals, we looked at:

- ambulance journeys;
- car journeys at peak traffic hours and non-peak hours; and
- public transport at peak hours.

These were categorised by 'lower super output area' (similar to postcode areas). We looked at how long it would take people living in each area to get to a hospital if their nearest hospital for a particular service were to change. It was important to look at how long it would take people on average and also what the longest journeys might be.

After looking at the evaluation, we proposed that Hillingdon Hospital and Northwick Park Hospital should be major hospitals, due mainly to their location. If either of these hospitals were not to provide more complicated healthcare, people in surrounding areas would have to travel much further to get to the next hospital providing those kinds of services. To put it another way, both Hillingdon and Northwick Park are the furthest distance away from any other possible major hospital site in NW London.

For example, people would have to travel up to 34 minutes by ambulance to get to their nearest hospital if Hillingdon Hospital no longer provided some services. This is much further than for people living near the other hospitals in NW London.

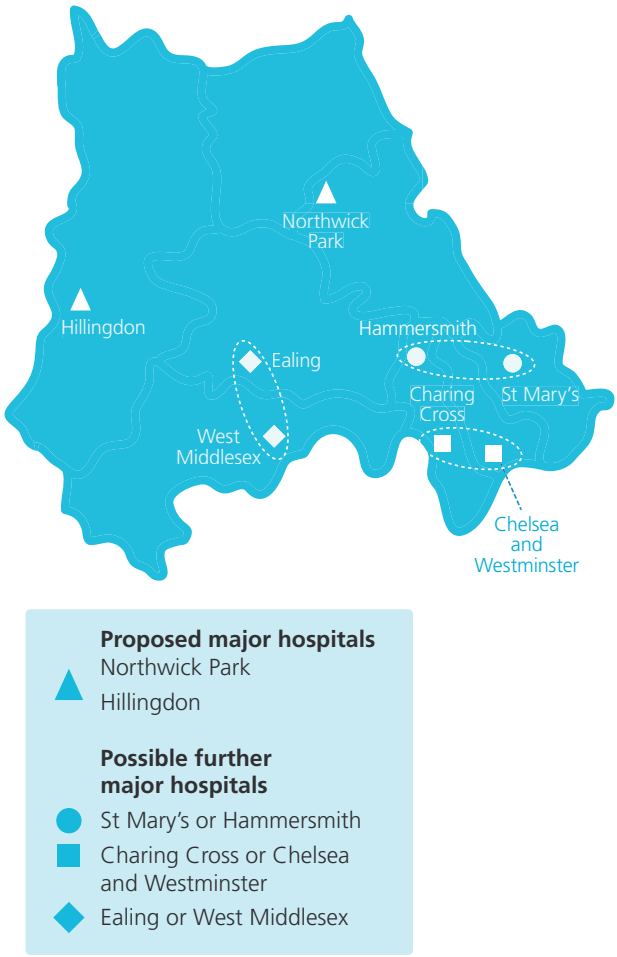
This means that two of the five major hospitals would be at Hillingdon Hospital and Northwick Park Hospital.

You can find more information on this analysis in our pre-consultation business case (volume 3, chapter 12) on our website at www.healthiernorthwestlondon.nhs.uk

There is not as much difference in travel times for people living near other hospitals in NW London. However, we wanted to make sure that the other three major hospitals were spread evenly across NW London. This is to make it easy for people to get to them. We looked at where people are likely to go if their nearest hospital did not provide some services, and proposed a choice of:

- a major hospital at either Ealing Hospital or West Middlesex Hospital;
- a major hospital at either Charing Cross Hospital or Chelsea and Westminster Hospital; and
- a major hospital at either Hammersmith Hospital or St Mary's Hospital.

This map shows these possible choices.



As an example, we would expect most patients who go to Ealing Hospital would go to West Middlesex Hospital (although they could of course choose to go to any other hospital) if some services were no longer provided at Ealing. And most patients who go to West Middlesex Hospital now would go to Ealing Hospital if some services were no longer provided at West Middlesex Hospital. We have based this on information on travel times provided by Transport for London. As a further test, we also looked at what would happen if both hospitals no longer provided some services and this showed that the time to get to the next nearest hospital would increase significantly. Assessing the choice between Charing Cross Hospital and Chelsea and Westminster Hospital and between St Mary's Hospital and Hammersmith Hospital gave similar results.

You can find more details on all the travel-time analysis in the pre-consultation business case (volume 3, chapter 12) on our website at www.healthiernorthwestlondon.nhs.uk

During the consultation, we will do further work on the effect of the proposals on travel and on plans for dealing with any travel issues (for example, access to public transport for people with a disability).

There are eight possible combinations of hospitals where there is a major hospital at:

- Hillingdon Hospital;
- Northwick Park Hospital;
- either Ealing Hospital or West Middlesex Hospital;
- either Charing Cross Hospital or Chelsea and Westminster Hospital; and
- either Hammersmith Hospital or St Mary's Hospital.

The next section looks at these options in more detail.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
St Mary's	Local hospital	Local hospital	Local hospital	Local hospital	Major hospital	Major hospital	Major hospital	Major hospital
Hammersmith	Major hospital and specialist hospital	Major hospital and specialist hospital	Major hospital and specialist hospital	Major hospital and specialist hospital	Specialist hospital	Specialist hospital	Specialist hospital	Specialist hospital
Charing Cross	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital
Chelsea and Westminster	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital	Major hospital	Local hospital
West Middlesex	Major hospital	Major hospital	Local hospital and elective hospital	Local hospital and elective hospital	Major hospital	Major hospital	Local hospital and elective hospital	Local hospital and elective hospital
Ealing	Local hospital	Local hospital	Major hospital	Major hospital	Local hospital	Local hospital	Major hospital	Major hospital
Central Middlesex	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital	Local hospital and elective hospital
Northwick Park	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital
Hillingdon	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital	Major hospital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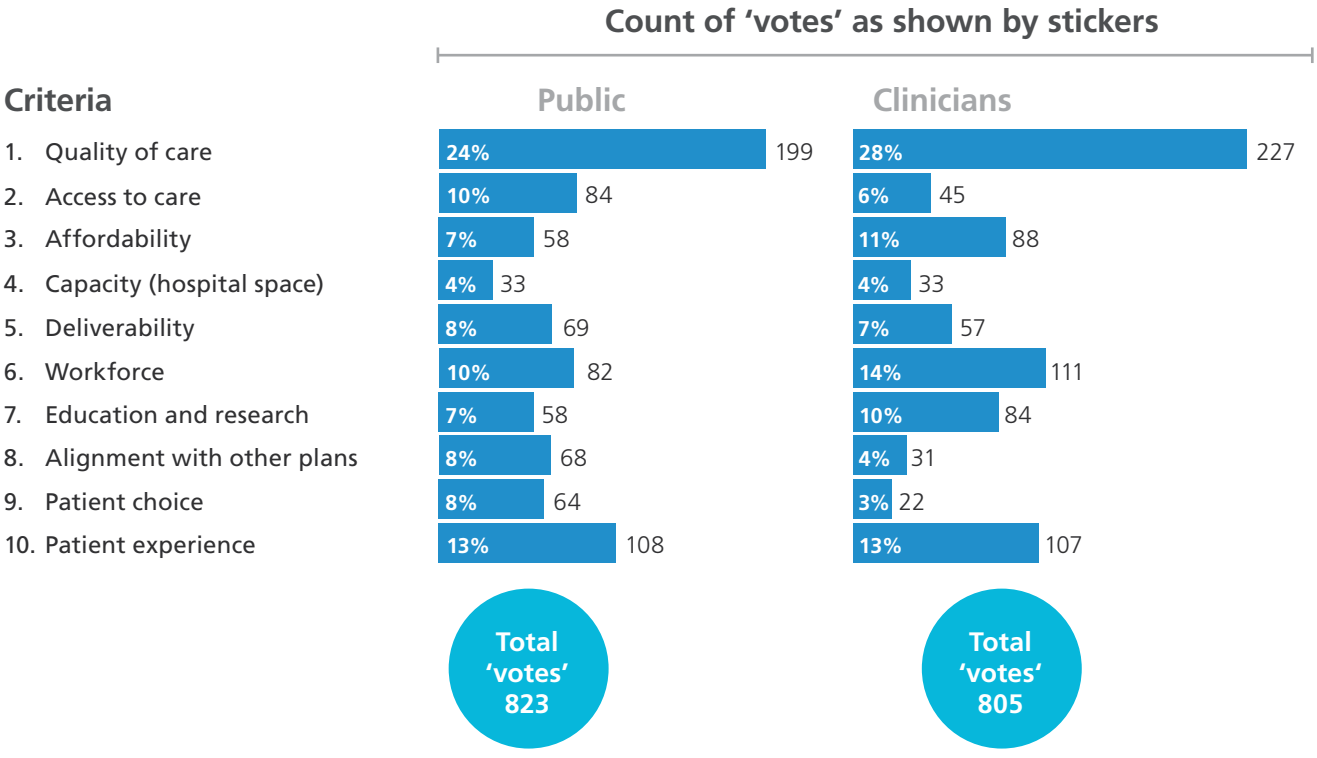
16. Which options are practical?

We asked the public and a wide range of clinicians what criteria (or measures) we should use to review the options and assess which were practical.

For example, at a public event in February 2012, 200 representatives of public and patient groups and clinicians ranked the most important criteria for them as follows.



From this work, we used the following criteria to review the options and assess which were practical.

Criteria	Sub criteria
1. Quality of care	• Clinical quality • Patient experience
2. Access to care	• Distance and time to access services • Patient choice
3. Value for money	• Capital cost to system • Transition costs • Viable Trusts and sites • Surplus for acute sector • Net present value
4. Deliverability	• Workforce • Expected time to deliver • Alignment with other plans
5. Research and education	• Disruption • Support current and developing research and education

To review how practical each option was using this criteria, we then asked a number of questions as follows.

- **Clinical quality** – Which options would provide better clinical quality in future using clinical surveys and measures?
- **Patient experience** – Which options would provide a better experience for patients using patient experience surveys and looking at the quality of the buildings and facilities?
- **Distance and time to access services** – Would any options keep to a minimum the increase in the average or total time it takes people to get to hospital by ambulance, car (at off-peak and peak times) and public transport?
- **Patient choice** – Which options would give people in NW London the greatest choice of hospitals for emergency care, maternity care and planned care across the greatest number of trusts?
- **Capital cost to the system** – Which options would have the lowest capital costs (cost of buildings and equipment)?
- **Transition costs** – Which options would have the lowest cost of transferring services between hospitals?
- **Viable trusts and sites** – Which options would have the lowest yearly subsidy and the fewest hospitals and trusts with a financial surplus of less than 1% (the lowest acceptable level of financial surplus allowed for trusts in the NHS)?
- **Surplus for acute sector** – Which options would give the largest financial surplus across all hospitals, to make sure that the proposed changes are affordable?
- **Net present value** – Which options would give the largest net present value (overall financial benefit) over the next 20 years?
- **Workforce** – Which options would provide the best workplace for staff (using staff satisfaction surveys)?
- **Expected time to deliver** – How long would it take to deliver the proposed changes in each option? A shorter delivery time means that benefits can be delivered earlier.
- **Fitting in with other strategies** – How well would each option fit with what is happening, or may happen, nationally or in London?
- **Disruption** – Which options best fit with current research and education to minimise disruption in these areas?
- **Support current and developing research and education delivery** – Which options would best support what is happening in research and education?

You can find all the information and analysis we used to answer these questions in the pre- consultation business case (volume 3, chapter 14) on our website at www.healthiernorthwestlondon.nhs.uk

Once we had answered these questions, we looked at the overall evaluation, which is shown in the table overleaf.

Summary of evaluation

	1	2	3	4	5	6	7	8
	• West Middlesex • Hammersmith • Chelsea and Westminster • Northwick Park • Hillingdon	• West Middlesex • Hammersmith • Charing Cross • Northwick Park • Hillingdon	• Ealing • Hammersmith • Chelsea and Westminster • Northwick Park • Hillingdon	• Ealing • Hammersmith • Charing Cross • Northwick Park • Hillingdon	• West Middlesex • St Mary's • Chelsea and Westminster • Northwick Park • Hillingdon	• West Middlesex • St Mary's • Charing Cross • Northwick Park • Hillingdon	• Ealing • St Mary's • Chelsea and Westminster • Northwick Park • Hillingdon	• Ealing • St Mary's • Charing Cross • Northwick Park • Hillingdon
Quality of care								
Clinical quality	++	++	++	++	++	++	++	++
Patient experience	++	+	+	–	++	+	+	–
Access								
Distance and time to access services	–	–	–	–	–	–	–	–
Patient choice	+	–	+	–	++	+	++	+
Affordability and value for money								
Capital cost to the system	– –	– –	– –	– –	+	+	+	+
Transition costs	– –	– –	– –	– –	–	–	–	–
Viable trusts and sites	+	+	– –	– –	+	+	– –	– –
Surplus for acute sector	+	+	–	– –	+	–	–	– –
Net present value	–	–	– –	– –	++	+	+	–
Deliverability								
Workforce	+	–	+	+	+	–	+	+
Expected time to deliver	–	–	– –	– –	+	+	– –	– –
Fitting in with other strategies	–	–	– –	– –	+	+	–	–
Research and education								
Disruption	–	–	–	–	+	+	+	+
Support current and developing research and education delivery	–	–	–	–	+	+	+	+

Our preferred viable option
Other viable options
Options we have evaluated as not being viable

++ High evaluation
– – Low evaluation

You can find the detailed evaluation in our pre-consultation business case (volume 3, chapter 14) on our website at www.healthiernorthwestlondon.nhs.uk.

This showed that three options (option 5, option 6 and option 7) were practical. The other options were not practical because they were assessed poorly against a number of criteria or because they did not show value for money (or both). We assessed option 5 as being much more practical than the other options and so this became the preferred option following this exercise. In the next section we describe the three most practical options in more detail and explain why option 5 is the preferred option.

21

Please consider the way we decided which hospitals to recommend as major hospitals, as set out in sections 15 and 16. Do you agree or disagree that this is the right way to choose between the various possibilities in order to decide which options to recommend?

22

Please say how important you think each of these criteria (measures) should be in choosing which hospitals should be major hospitals, rating their importance on a scale where 10 means 'absolutely vital' and 0 means 'not important at all'. (We have given more details on the criteria in the list on page 53).

Hammersmith Hospital

As we have assessed options 1 to 4 as not practical, this means we do not propose Hammersmith Hospital as a major hospital in any of the consultation options. Today, Hammersmith Hospital provides a wide range of specialist services, a very limited A&E service and maternity services. Under all the options for consultation, Hammersmith Hospital will keep all of its specialist services and its maternity unit. The only proposed change is to the A&E department, which would become an urgent care centre, and the non-specialist services that support this.

The reasons that we are not proposing Hammersmith Hospital as a major hospital are as follows.

- **Significant extra cost**. Hammersmith Hospital doesn't provide important services such as emergency general surgery and orthopaedics at the moment, and significant capital spending (spending on buildings and equipment) would be needed to provide these services at Hammersmith Hospital.

- **Complicated to deliver**. A major hospital at Hammersmith Hospital rather than St Mary's Hospital would mean moving a large number of services from St Mary's Hospital, including the major trauma centre and paediatric services, which would be a challenge.

- **Allows an extra maternity unit**. The maternity unit at Queen Charlotte's and Chelsea Hospital would continue to be provided under options where Hammersmith Hospital is not a major hospital (the specialist services at the Hammersmith Hospital means that the Hammersmith Hospital can provide the senior clinicians and back-up needed to run a safe maternity unit even if Hammersmith Hospital were not a major

hospital), giving an extra maternity unit in NW London.

- **Better support for research and education**. Most medical research in NW London is currently carried out at Hammersmith Hospital, with some research at St Mary's Hospital and Chelsea and Westminster Hospital. If Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital becomes a major hospital, current research arrangements can continue at both those sites.

Central Middlesex Hospital

We have not proposed Central Middlesex Hospital as a major hospital in any of the consultation options. We have recommended that Central Middlesex Hospital should not be a major hospital but an elective hospital with local hospital services. This is because it is already providing these services, its major A&E services are already under pressure (A&E emergency round-the-clock care had to be suspended in late 2011 because not enough senior emergency care doctors were available on-site), essential services for a major hospital – emergency surgery, paediatrics and maternity – are not provided on-site and patients could access these major emergency care services elsewhere in other nearby hospitals.

23

What further comments, if any, do you have on any of the issues raised in sections 15 or 16 of this consultation document? (For example, please tell us if you think there are any criteria that we have missed and which should also be taken into account in choosing which hospitals should be major hospitals).

17. The three options for major hospitals

In this section, we describe the three options for major hospitals. We also explain why there is a preferred option.

To make consultation easier, we have renumbered the options.

- Option 5 has become option A
- Option 6 has become option B
- Option 7 has become option C

All our options for consultation will mean that quality of care will improve outside and in hospitals.

- **Improved care outside hospital**. Under all options, improved quality of healthcare outside hospitals will support people to lead healthier lifestyles, improve access to services, allow people to take control of their own health and mean care is more co-ordinated.

- **Improved quality of care in hospitals**. Under all options, reducing the number of hospitals providing some services will mean there will be more specialist and experienced doctors available for more of the time, and that they will be able to build and maintain the skills and expertise they need to deliver high-quality care. There will also be more back-up for services.

All options will mean that some patients would have to travel a little longer for some aspects of their care, but on average no more than 6 minutes longer. As described in section 7, clinicians agree it is more important that patients are taken to the right place for treatment by the right clinicians even if they need to travel further.

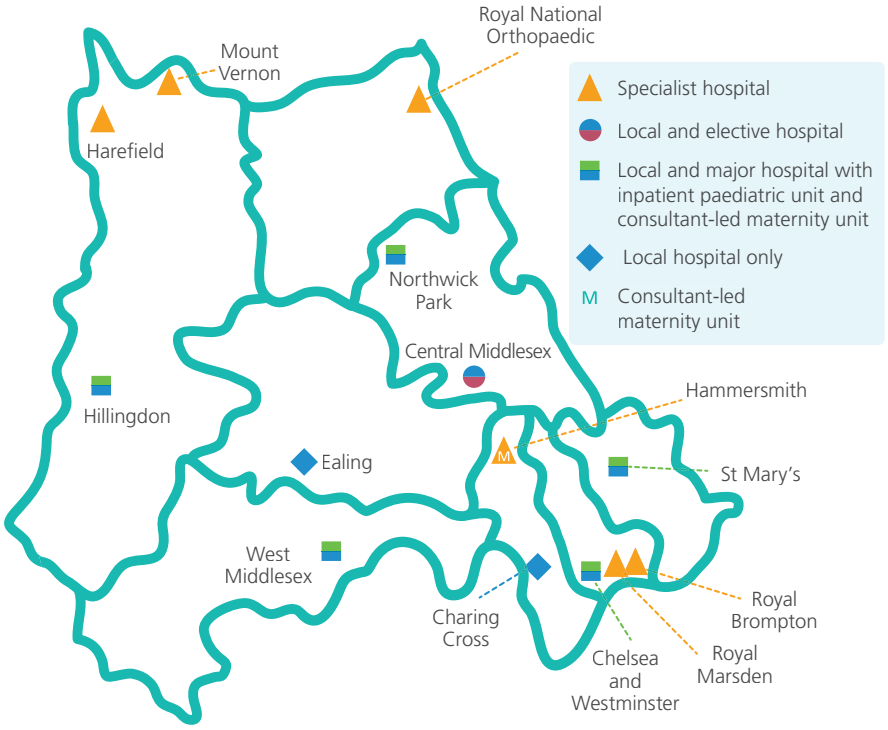
Option A (preferred option)

This option is the preferred option. It has Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital as major hospitals. It has Central Middlesex Hospital as a local and elective hospital and Hammersmith Hospital as a specialist hospital. Ealing Hospital and Charing Cross Hospital are proposed as local hospitals.

Some services will no longer be available in some hospitals and instead will be provided at neighbouring hospitals where there would be more senior, experienced staff available and extra back-up in case of problems. Some specialist services will also need to move where hospitals become local hospitals. We have outlined the services provided at each site before and after the proposed changes in the table on page 59.

Under this option, around 91% of services would not be affected by the proposed changes. The proportion of services that would be affected under this option is

Option A (preferred option)



relatively low, with 22% of inpatient cases, 14% of A&E cases and 5% of outpatient cases likely to move. Similarly, it is estimated that 81% of the workforce would not be affected by the changes, with most of those affected needing to move location to provide services either within a neighbouring hospital or within the community.

We believe this option would deliver the greatest benefits for NW London for the following reasons.

- **Good use of buildings**. Chelsea and Westminster Hospital and West Middlesex Hospital both consist of very recently built buildings, with space that is suitable for both current and future requirements. Given what we have already said about the need to manage and maintain NHS buildings in NW London, and the difficulty of building new ones, this is a major factor.

- **Value for money**. This option would need relatively limited amounts of capital spending (on buildings and equipment) and it would leave NW London with a predicted overall financial surplus greater than 2%. Only one trust (one hospital) is predicted to have a deficit in this option. We predict this option will provide the best return on investment of all the options. It means the NHS in North West London would be in a much better financial position than if nothing were to change.

- **Easy to deliver**. This option corresponds most closely with services already being delivered at each hospital, and with other changes taking place outside the 'Shaping a healthier future' programme. So, the scale of the change needed would be smallest under this option.

- **Supports research and education**. Most important medical research in NW London is currently carried out at Hammersmith Hospital, St Mary's Hospital and Chelsea and Westminster Hospital. Under this option, Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital becomes a major hospital, which would mean current research arrangements can continue at both those sites.

Option A

		Local hospital		Major hospital								Elective hospital		Other	
		Urgent care centre	Outpatients and diagnostics	A&E (24 hours a day, 7 days a week)	Emergency surgery	Non-elective medicine	Non-elective surgery	Complex elective medicine	Complex elective surgery	ICU level 3	Inpatient paedatrics	Obstetrics and maternity unit	Non-complex elective surgery or medicine (or both)	High Depend-ency	Heart attack	HASU
● Charing Cross	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔						✔
	Future	✔	✔													
Chelsea and Westminster	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	S	✔				
● Ealing	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔													
St Mary's	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
West Middlesex	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
● Central Middlesex	*Current*	✔	✔			✔	✔		✔	✔			✔	✔		
	Future	✔	✔										✔	✔		
Hammersmith (incl. Queen Charlotte's)	*Current*	✔	✔	L	S	S	S	✔	S	✔		✔			✔	
	Future	✔	✔		S	S	S	S	S	S		✔	S	S	✔	
Hillingdon	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Northwick Park	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔

KEY

● Site specifically affected by option

✔ Service on-site

S Specialist service on-site

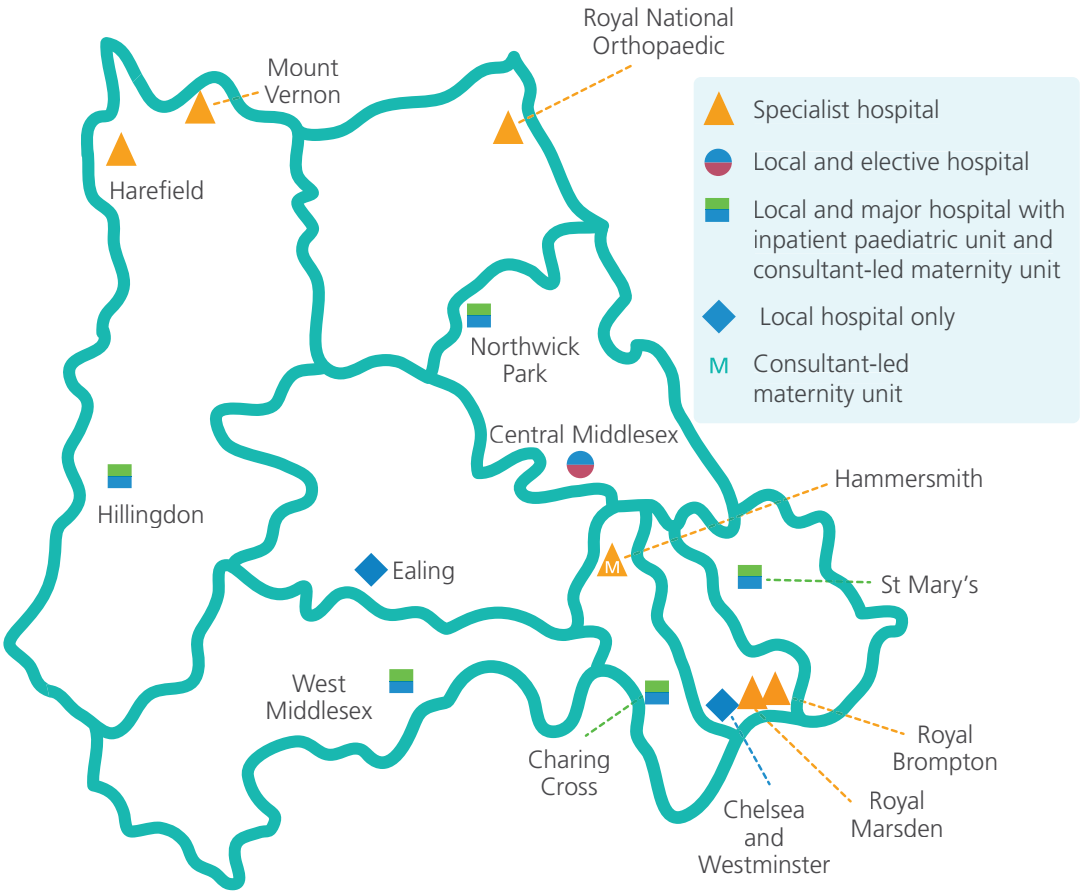
L Limited service on-site

Option B

This option has Charing Cross Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital as major hospitals. It has Central Middlesex Hospital as a local and elective hospital, and Hammersmith Hospital as a specialist hospital. Ealing Hospital and Chelsea and Westminster Hospital would be local hospitals.

Some services will no longer be available in some hospitals and instead will be provided at neighbouring hospitals where there would be more senior, experienced staff available and extra back-up in case of problems. Some specialist services will also need to move where hospitals become local hospitals. We have outlined the services provided at each site before and after the proposed changes in the table opposite.

Under this option, around 87% of services would not be affected by the proposed changes. The proportion of services that would be affected under this option is relatively low, with 25% of inpatient cases, 17% of A&E cases and 9% of outpatient cases likely to move. Similarly, it is estimated that 79% of the workforce would not be affected by the changes, with most of those affected needing to move location to provide services either within a neighbouring hospital or within the community.



Option B

		Local hospital		Major hospital								Elective hospital		Other	
		Urgent care centre	Outpatients and diagnostics	A&E (24 hours a day, 7 days a week)	Emergency surgery	Non-elective medicine	Non-elective surgery	Complex elective medicine	Complex elective surgery	ICU level 3	Inpatient paedatrics	Obstetrics and maternity unit	Non-complex elective surgery or medicine (or both)	High Depend-ency	Heart attack	HASU
Charing Cross	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔						✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
● Chelsea and Westminster	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔													
● Ealing	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔													
St Mary's	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
West Middlesex	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
● Central Middlesex	*Current*	✔	✔			✔	✔		✔	✔			✔	✔		
	Future	✔	✔										✔	✔		
Hammersmith (incl. Queen Charlotte's)	*Current*	✔	✔	L	S	S	S	✔	S	✔		✔			✔	
	Future	✔	✔		S	S	S	S	S	S		✔	S	S	✔	
Hillingdon	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				
Northwick Park	*Current*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔
	Future	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔				✔

KEY

● Site specifically affected by option

✔ Service on-site

S Specialist service on-site

L Limited service on-site

This option would deliver benefits for NW London.

- **Good use of some buildings**. This option has West Middlesex Hospital as a major hospital, which would be a good use of high-quality buildings but does not include a major hospital at Chelsea and Westminster Hospital, which also has high-quality buildings.

- **Value for money**. This option would need relatively limited amounts of capital spending (on buildings and equipment). Two trusts (two hospitals) would continue to have a predicted deficit in this option and the predicted overall financial surplus would be less than 2% across NW London. This option is predicted to provide a positive return on investment, although less than for option A. It means the NHS in NW London would be in a better financial position than if nothing changes.

- **Fairly easy to deliver**. This option corresponds reasonably well with services already being delivered at each hospital, and with other changes taking place outside the 'Shaping a healthier future' programme. However, the maternity and paediatric units at Chelsea and Westminster Hospital would have to be moved elsewhere under this option.

- **Supports research and education**. Most important medical research in NW London is currently carried out at Hammersmith Hospital, St Mary's Hospital and Chelsea and Westminster Hospital. Under this option, Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital a major hospital, which would mean current research arrangements can continue at both those sites.

Option B gives fewer benefits than option A, because it would:

- **be more difficult to deliver** – Chelsea and Westminster Hospital has a large obstetric unit, and if it were not chosen as a major hospital, these beds would need to be moved elsewhere;

- **be a poor use of buildings** – it would not make the best use of the high-quality buildings at Chelsea and Westminster Hospital;

- **give worse value for money** – it would be more expensive to put in place than option A and would result in a lower financial surplus across NW London;

- **leave two trusts (two hospitals) in deficit** – two trusts (two hospitals) would still lose money compared with option A; and

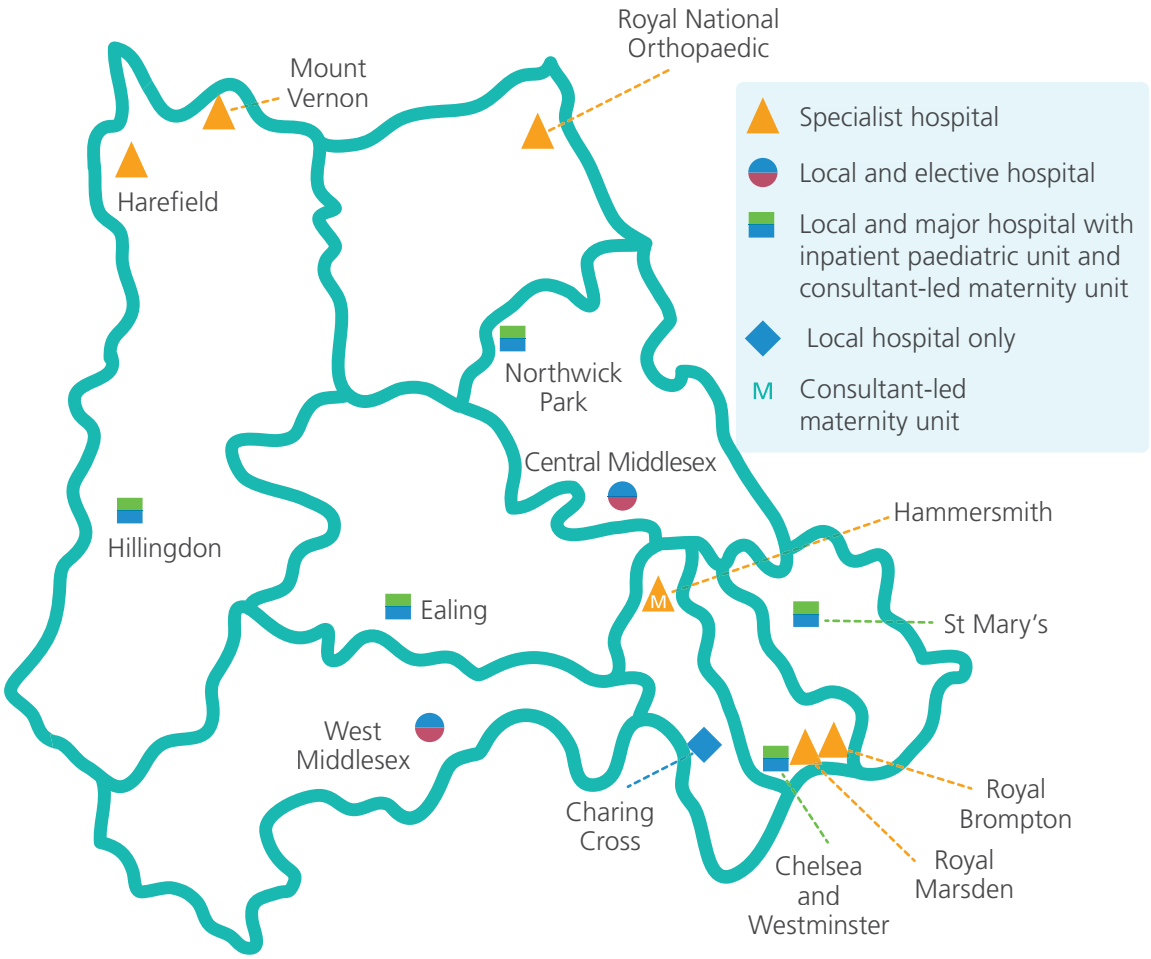
- **reduce patient choice** – including Charing Cross Hospital rather than Chelsea and Westminster Hospital would mean only four trusts running major hospitals, rather than five.

Option C

This option has Chelsea and Westminster Hospital, Ealing Hospital (with the stroke unit at West Middlesex Hospital moved to Ealing Hospital), Hillingdon Hospital, Northwick Park Hospital and St Mary's Hospital as the major hospitals. It has Central Middlesex Hospital and West Middlesex Hospital as a local and elective hospital and Hammersmith Hospital as a specialist hospital. Charing Cross Hospital is proposed as a local hospital.

Some services will no longer be available in some hospitals and instead will be provided at neighbouring hospitals where there would be more senior, experienced staff available and extra back-up in case of problems. Some specialist services will also need to move where hospitals become local hospitals. We have outlined the services provided at each site before and after the proposed changes in the table opposite.

Under this option, around 91% of services would not be affected by the changes. The proportion of services that would be affected under this option is relatively low, with 18% of inpatient cases, 15% of A&E cases and 5% of outpatient cases likely to move. Similarly, it is estimated that 81% of staff would not be affected by the changes, with most of those affected needing to move location to provide services either within a neighbouring hospital or within the community.



Option C

		Local hospital		Major hospital									Elective hospital		Other	
		Urgent care centre	Outpatients and diagnostics	24/7 A&E (24 hours a day, 7 days a week) A&E	Emergency surgery	Non-elective medicine	Non-elective surgery	Complex elective medicine	Complex elective surgery	ICU level 3	Inpatient paedatrics	Obstetrics and maternity unit	Non-complex elective surgery or medicine (or both)	High Depend-ency	Heart attack	HASU
● Charing Cross	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓
	Future	✓	✓													
Chelsea and Westminster	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
	Future	✓	✓	✓	✓	✓	✓	✓	✓	✓	S	✓				
Ealing	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
	Future	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓				
St Mary's	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
	Future	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓
● West Middlesex	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
	Future	✓	✓										✓	✓		
● Central Middlesex	*Current*	✓	✓			✓	✓		✓	✓			✓	✓		
	Future	✓	✓										✓	✓		
Hammersmith (incl. Queen Charlotte's)	*Current*	✓	✓	L	S	S	S	✓	S	✓		✓			✓	
	Future	✓	✓		S	S	S	S	S	S		✓	S	S	✓	
Hillingdon	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
	Future	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Northwick Park	*Current*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓
	Future	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				✓

KEY

● Site specifically affected by option

✓ Service on-site

S Specialist service on-site

L Limited service on-site

This option would deliver benefits for NW London.

- **Good use of some buildings**. This option has Chelsea and Westminster Hospital as a major hospital, which would be a good use of high-quality buildings but does not include a major hospital at West Middlesex Hospital, which also has high-quality buildings.

- **Value for money**. This option would need more capital spending on buildings and equipment than option A. We predict that two trusts (three hospitals) would have a deficit in this option and the predicted financial surplus would be less than 2% across NW London. So, this option would provide a positive return on investment, but less than for option A. It means the NHS in NW London would be in a better financial position than if nothing changes, under this option.

- **Supports research and education**. Most important medical research in NW London is currently carried out at Hammersmith Hospital, St Mary's Hospital and Chelsea and Westminster Hospital. Under this option, Hammersmith Hospital becomes a specialist hospital and St Mary's Hospital a major hospital, which would mean current research arrangements can continue at both those sites.

Option C is not as good an option as option A, because it would:

- **give worse value for money** – it would not save as much money, and is predicted to be the least financially secure of the options;

- **be a poor use of buildings** – it would not make the best use of the high-quality buildings at West Middlesex Hospital;

- **leave two trusts (three hospitals) in deficit** – two trusts (three hospitals) would still lose money compared with option A; and

- **be more difficult to deliver** – the stroke unit at West Middlesex Hospital would need to be moved as it would not be able to provide this service safely without major hospital back-up.

We have carefully considered whether there should be a 'preferred option' for consultation, since the three options – A, B and C – are all practical. However, because the Joint Committee of Primary Care Trusts, which is leading this consultation, believes that option A delivers the greatest benefits for NW London, it would be misleading not to say so.

Having said that, this is a consultation aimed at gathering people's views. So we are putting all three options forward and inviting your views on which option will have the most benefits.

As part of the consultation, we would encourage healthcare providers, including from the independent and voluntary sectors, to make proposals for new and innovative ways of delivering services. We will make sure that information is available so that anyone who is interested in making proposals is able to do so, and we will fully and fairly consider any responses.

Thinking about the proposals put forward in sections 16 and 17, please say how far you support or oppose each of the three proposed options for the location of major hospitals in North West London. (You can support more than one of the options if you want.) Please explain why you support or oppose each option.

24

24a. Option A (the preferred option):
Major hospitals – Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital.
Elective and local hospital – Central Middlesex Hospital.
Local hospitals – Charing Cross Hospital, Ealing Hospital.
Specialist hospital (with maternity unit) – Hammersmith Hospital

24b. Why is this your answer?

25

25a. Option B:
Major hospitals – Charing Cross Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital.
Elective and local hospital – Central Middlesex Hospital.
Local hospitals – Chelsea and Westminster Hospital, Ealing Hospital.
Specialist hospital (with maternity unit) – Hammersmith Hospital.

25b. Why is this your answer?

26

26a. Option C:
Major hospitals – Chelsea and Westminster Hospital, Ealing Hospital (with the stroke unit at West Middlesex Hospital moved to Ealing Hospital), Hillingdon Hospital, Northwick Park Hospital and St Mary's Hospital.
Elective and local Hospital – Central Middlesex Hospital and West Middlesex Hospital.
Local hospitals – Charing Cross Hospital.
Specialist hospital (with maternity unit) – Hammersmith Hospital.

26b. Why is this your answer?

27

27a. All the options above include the recommendation that Central Middlesex Hospital should be an elective and local hospital. How far do you support or oppose the recommendation that Central Middlesex Hospital should be an elective and local hospital?

27b. Why is this your answer?

28

28a. All the options above include the recommendation that Hillingdon Hospital should be a major hospital. How far do you support or oppose the recommendation that Hillingdon Hospital should be a major hospital?

28b. Why is this your answer?

29

29a. All the options above include the recommendation that Northwick Park Hospital should be a major hospital. How far do you support or oppose the recommendation that Northwick Park Hospital should be a major hospital?

29b. Why is this your answer?

30

30a. All the options above include the recommendation that Hammersmith Hospital should be a specialist hospital. There would continue to be a maternity unit at Hammersmith. How far do you support or oppose the recommendation that Hammersmith Hospital should be a specialist hospital with a maternity unit?

30b. Why is this your answer?

31

Are there any other options we should consider when making our decisions? If so, please give your reasons for suggesting these.

18. Proposals for changes to specialist services

Specialist hospitals already provide high-quality services in NW London and cover the local population (and many other parts of London too) very well.

So specialist hospitals will stay largely as they are.

However, as part of this consultation, we are recommending two particular changes to specialist services, as well as changes to specialist services where hospitals become local hospitals.

1. Moving the hyper-acute stroke unit (HASU) from Charing Cross Hospital to St Mary's Hospital under options where Charing Cross Hospital is not a major hospital.

If Charing Cross Hospital were to become a local hospital, we could not maintain a hyper-acute stroke unit (HASU) there. The HASU would need to move to a major hospital close to the Charing Cross Hospital site. The stroke and major trauma consultation in 2009 showed a preference for putting HASUs on the same site as major trauma centres, as they need similar back-up and support. As there is now a major trauma centre at St Mary's Hospital, we propose to move the HASU from Charing Cross Hospital to St Mary's Hospital in option A and option C, where Charing Cross Hospital is a local hospital.

2. Moving services from the Western Eye Hospital to St Mary's Hospital

The Western Eye Hospital is the specialist ophthalmology hospital in NW London and part of Imperial Healthcare NHS Trust. It is the only hospital to offer a 24-hour emergency eye-care service in NW London for ambulance and walk-in cases. The service uses a minor surgical theatre, a triage system, inpatient beds and theatres. The Western Eye Hospital also offers outpatients, inpatients and day-care surgery.

The hospital is located on its own just off Marylebone Road. As part of Imperial's strategy, they would like to move these services to one of their other hospital sites and, so that people can understand all the changes being proposed in NW London, we have included this proposal in this consultation.

Separating Western Eye Hospital services from the main hospital services at St Mary's Hospital creates service and financial waste. By combining services, Imperial will be able to offer an integrated ophthalmologic service for urgent and non-urgent patient needs. There will be one place for all ophthalmologic emergencies, reducing the need for transferring patients and allowing clinicians to work more economically and effectively.

Imperial have looked at the option of moving services to each of its other sites (St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital). It thinks that

the best option is to move the Western Eye Hospital to St Mary's Hospital as this would:

- have little effect on patient access compared with the current site;
- improve clinical performance because of combining services and putting them with major trauma and paediatrics at St Mary's Hospital; and
- be the better long-term option (clinically and financially) for Imperial.

Imperial estimates the net costs of moving to St Marys would be between £5 million and £15 million, with the lower amount being more likely as part of broader site redevelopment at St Mary's.

You can find more details in our pre-consultation business case (Appendix K) on our website at www.healthiernorthwestlondon.nhs.uk

32

32a. Do you agree or disagree that the hyper-acute stroke unit, which was designated to Charing Cross following the stroke and major trauma consultation, should move to be with the major trauma unit at St Mary's?

32b. Why is this your answer?

33

33a. Do you agree or disagree that the Western Eye Hospital should be relocated with the major hospital at St Mary's?

33b.Why is this your answer?

19. Making this work for patients

We have worked long and hard, with patient representative groups and others, to make sure that the 'Shaping a healthier future' programme as it is put in place over the next few years in NW London should benefit patients, not have a negative effect on them.

But because there is understandable concern about some areas of change to NHS services, we want, in particular, to highlight the following.

- We are investing in developing bigger, better specialist teams in major hospitals and in community services.

- We are investing to increase services outside hospital and have plans for new facilities to deliver these services.

- The main parts of the proposed changes have all been delivered before, in this country and around the world, and so are known to be a successful way to reorganise health services to prepare for future demands.

- Most patients using NW London hospitals' emergency services are already using minor injuries units or urgent care centres – they are not actually using, or needing to use, major A&E departments. So moving the major A&E departments away from some locations would not affect many of the patients using these same hospital sites already.

- It will take longer for some people to get to some services, or visit relatives. But the benefits of better, specialised care at these hospitals, and from more care being delivered closer to home, far outweigh the inconvenience of these increased journeys. Those using the NHS have consistently said in surveys that they would rather travel further to receive better care – and would want the same for their families.

- Many health services provided in the community – such as GP services and mental-health services – are already being improved and would need a relatively modest investment of time and money to cope with the extra services that would switch from being provided in hospitals at the moment to being provided by facilities closer to home, such as in improved GP surgeries, new health centres, and new community facilities. We have promised that we will not make changes to hospitals until any alternative services that are necessary are in place.

- To find out whether our proposals might unfairly disadvantage some communities, we have done an independent equalities impact review which looked at how

the proposed changes would affect people such as young children, ethnic communities, women and the elderly. This review showed that in most cases these groups would not be unfairly disadvantaged. We are developing an action plan to tackle any potential disadvantages that have been reported. You can see the full report for this review on our website at www.healthiernorthwestlondon.nhs.uk

34

Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here.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20. Next steps

We are keen to continue the discussion with patients, the public, and those who may be affected by the proposed changes to health services in NW London.

There is a recognised process for doing this as, by law, the NHS has to consult patients and the public on any major change to local health services. Government guidance on this says we must:

"1. Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.

2. Be clear about what the proposals are, who may be affected, what questions are being asked and the timescale for responses.

3. Ensure that the consultation is clear, concise and widely accessible.

4. Give feedback regarding the responses received and how the consultation process influenced the policy.

5. Monitor the effectiveness of the consultation, including through the use of a designated consultation co-ordinator.

6. Ensure the consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate."

So, through a large-scale consultation running for 14 weeks from 2 July to 8 October, we are asking people for their opinions on these options for change, making sure we involve patients and the public more widely. (We have added an extra two weeks to the minimum consultation time because it is taking place over the summer.)

There will be focus groups, roadshows, events in hospitals, and other events around all eight NW London boroughs (and the three outside NW London who may be affected by the changes), to make sure we involve as many people and communities as possible, including some who are sometimes referred to as 'seldom heard' groups. The aim is to explain, to listen, and to receive views from as many people as possible.

We will then spend some time assessing people's views, before making a further report, in early 2013. The Joint Committee of Primary Care Trusts will then make the final decision on changes to services. The Joint Health Overview and Scrutiny Committee, which is made up of representatives from each of the local authorities in NW London, will closely check our consultation and proposed plans.

If the changes are agreed they will take at least three years to put in place. Work to develop services that can be provided in the home, GP surgeries and health centres has already started and only once these services are in place will changes to hospitals be made.

Glossary

A&E – accident & emergency is a service available 24 hours a day, seven days a week where people receive treatment for medical and surgical emergencies that are likely to need admission to hospital. This includes severe pneumonia, diabetic coma, bleeding from the gut, complicated fractures that need surgery, and other serious illnesses.

Acute care – acute care refers to short-term treatment, usually in a hospital, for patients with any kind of illness or injury.

Acute trust – NHS acute trusts manage hospitals. Some are regional or national centres for specialist care, others are attached to universities and help to train health professionals. Some acute trusts also provide community services.

Bundle – a combination of relevant 'packages of care' for a patient. For example, a bundle for a patient with diabetes could include podiatry, dietetics, diabetes nursing and ophthalmology.

Cardiothoracic – is the field of medicine involved in surgical treatment of diseases affecting organs inside the thorax (the chest) – generally treatment of conditions of the heart (heart disease) and lungs (lung disease).

Cardiovascular – this refers to the heart and blood vessels. Cardiovascular diseases affect the function of the cardiovascular system, which carries nutrients and oxygen to the tissues of the body while removing carbon dioxide and other wastes from them.

CCG – clinical commissioning group. These are the health commissioning organisations which will replace primary care trusts (PCTs) in April 2013. CCGs are led by GPs and represent a group of GP practices in a certain area. They are currently shadowing the PCTs and will be responsible for commissioning healthcare services in both community and hospital settings from April 2013 onwards.

Care outside hospital – care that takes place outside of hospital, in a community setting. This could be a patient's home, community bed or community health centre.

Centralise – a principle of the 'Shaping a healthier future' programme, which is about bringing more services together on a number of specific sites to create a greater level of expertise.

Complex elective medicine or surgery – a planned operation or medical care where the patient may need to be in a high-dependency unit while recovering from the operation, either because the operation is complex or because they have other health problems.

Continuity of care – an integrated care project that has been launched in Hammersmith and Fulham. The project aims to improve outcomes for patients at minimal costs and reduce treatment or stays in hospital.

COPD – chronic obstructive pulmonary disease. COPD is a lung disease which causes difficulty or discomfort in breathing.

CQC – Care Quality Commission – this is an organisation funded by the Government to

check all hospitals in England to make sure they are meeting government standards, and to share their findings with the public.

Deficit – when spending is greater than income.

Elective hospital – this is where patients go if they need an operation which is not urgent and so can be planned.

Emergency surgery – surgery that is not planned and which is needed for urgent conditions. This includes surgery for appendicitis, perforated or obstructed bowel, and gallbladder infections. It is also known as non-elective surgery.

Financial surplus – when income is greater than spending.

Foundation trust (FT) – NHS Foundation Trusts are not-for-profit corporations. They are part of the NHS yet they have greater freedom to decide their own plans and the way services are run. Foundation trusts have members and a council of governors. The aim is that eventually all NHS trusts will be FTs.

GP network or cluster – a smaller group of GP practices within a borough or CCG area (see CCG above).

HealthWatch – these are new organisations which will replace LINks (see below) as part of the restructure of the NHS. Their role is to make sure patients are involved in developing and changing NHS services and to provide support to local people. There will be a national HealthWatch to oversee the local HealthWatch and provide advice as an independent part of the CQC (see above).

Health centre or 'hub' – a setting for care outside hospital which will be adapted from existing community sites to provide other services locally, serving as a support 'hub' to local healthcare teams. The services offered will vary depending on local needs and will range from bases for multidisciplinary teams to 'one-stop' centres for GP services, diagnostics and outpatient appointments.

Heart attack centre – a centre which treats people who have had a heart attack.

Health and well-being board (HWB) – part of the NHS restructure, the aim of these boards is to encourage joint working between the NHS and local authorities across health and social care. HWBs are expected to be up and running in April 2013.

High-dependency unit – treats conditions that need intensive nursing support, such as people who are ill with pneumonia or who have had major surgery.

Hyper-acute stroke unit (HASU) – hospital wards that specialise in treating people who are having a stroke.

Integrated care pilot (ICP) – a joint venture led by commissioners and providers of primary, community, acute, social and mental-health care for people aged 75 and over with diabetes. The aim is to offer integrated care to improve the outcome for patients and reduce unnecessary stays in hospital.

Inpatient – a patient who is admitted to a hospital, usually for 24 hours, for treatment or an operation.

Inpatient paediatrics – these units treat sick children who require a stay in hospital.

Integrate – a principle of this programme which refers to creating more co-ordinated care for the patient, making sure all parts of the NHS and social services work more closely and effectively together.

Interdependency – where some clinical services need other clinical services to be based on the same site for particular types of care to be successfully and fully delivered together.

Interventional radiology – uses minimally invasive image-guided procedures to diagnose and treat diseases in nearly every organ system.

Intensive care – these units provide support for patients after complex surgery, or patients needing multiple organ support such as ventilation and dialysis.

Key performance indicator (KPI) – targets that are agreed between the provider and commissioner of each service, which performance can be tracked against.

Level 3, as in level 3 intensive care unit - ICUs are sections within a hospital that look after patients whose conditions are life-threatening and need constant, close monitoring and support from equipment and medication to keep normal body functions going. Level 3 ICU is for patients who need advanced respiratory support alone or basic respiratory support with the support of at least two organ systems. This level includes all patients with complex needs who need support for multi-organ failure.

LINks – local involvement networks. LINks are made up of individuals and community groups whose goal is to improve health and social care services. They are funded by local councils, although they are independent of the Government. In 2013 they will be replaced by HealthWatch (see above).

Local hospital – a type of hospital proposed in the changes. Local hospitals will include urgent care centres, which provide the services that three-quarters of people go to hospital for – such as everyday illnesses, minor injuries and long-term conditions such as diabetes or asthma.

Localise – a principle of this programme, which is to deliver as much care as possible in the most convenient locations, making sure people have earlier and easier access to treatment.

Major hospital – a type of hospital proposed in the changes. A major hospital will include full A&E, paediatrics and maternity services.

Maternal deaths – death of a women while pregnant or within 42 days of end of pregnancy, from any cause related to the pregnancy.

Maternity – relating to pregnancy, childbirth and immediately following childbirth.

Multi-disciplinary group (MDG) – sometimes referred to as a multidisciplinary team. These are groups of professionals from primary, community, social care and mental-health services who work together to plan a patient's care.

Neonatal – relating to newborn infants.

Non-complex elective surgery or medicine (or both) – this includes hernia repairs, knee replacements and planned gallbladder operations, usually as day cases.

Non-elective medicine – treatment for illnesses that is not planned, including severe pneumonia, flare-ups of inflammatory bowel disease, severe asthma attacks and worsening of COPD, needing admission to hospital.

Non-elective surgery – see emergency surgery

Obstetric – the care associated with giving birth.

Obstetrics and maternity unit – where babies are delivered and women with complex pregnancies, such as expectant mothers with diabetes or heart disease, or who are pregnant with triplets, are monitored.

Overview and Scrutiny Committee (OSC), Health OSC (HOSC) and Joint Health OSC (JHOSC) – the committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and if necessary challenging,

programmes such as the 'Shaping a healthier future' programme. Parts of consultation, such as the length of the consultation period, have to be agreed by them.

Outpatient – a patient who attends an appointment to receive treatment without needing to be actually admitted to hospital, unlike an inpatient. Outpatient care can be provided by hospitals, GPs and community providers and is often used to follow up after treatment or to assess for further treatment.

Outpatients and diagnostics – for people who need specialist advice or investigation in hospital. This includes support for insulin-dependent diabetics or neurological conditions such as multiple sclerosis. It also includes minor surgery, ECGs, x-rays, ultrasounds, CT and MRI scans.

Package of care – a term used to describe a combination of services put together to meet a person's assessed healthcare needs. It outlines the care, services and equipment a person needs to live their life in a dignified way.

Patient pathway or journey – this is a term used to describe the care a patient receives from start to finish of a set timescale, in different stages. There can be integrated care pathways which include multi-disciplinary services for patient care (see MDG above).

Paediatric services – this refers to healthcare services for babies, children and adolescents.

Patient and public advisory group (PPAG) – there is a London-wide PPAG as well as a PPAG in NW London. Their role is to make sure the interests of patients and the public are represented in the NHS. Members usually include representatives of local LINks, hospital patient groups, local clinical commissioning groups, the London PPAG and NHS staff.

Primary care – services which are the main or first point of contact for the patient, provided by GPs, community providers and so on.

Primary care trust (PCT) – PCTs commission primary, community and secondary care from providers. To be replaced by CCGs (see above) in April 2013.

Quality, innovation, productivity and prevention (QIPP) – the Department of Health QIPP agenda aims to achieve up to £20 billion of efficiency savings by 2015 by making sure that each pound spent is used to bring maximum benefit and quality of care to patients.

Secondary care – hospital or specialist care that a patient is referred to by their GP or other primary care provider.

Specialist hospital – a hospital which provides specialist care for particular conditions, for example cancer or lung disease.

Stroke – a stroke is the sudden death of brain cells in a particular area due to inadequate blood flow.

Trauma, as in major trauma centre or trauma centre – these centres treat major trauma patients who have complex injuries – either one very serious injury or a number of injuries – which make managing these patients very challenging. They need expert care from a large number of different specialties to give them the best chance of survival and recovery.

Urgent care centre (UCC) – a centre that is open 24 hours a day, seven days a week. These centres will treat most illnesses and injuries that people have which are not likely to need treatment in hospital. This includes chest infections, asthma attacks, simple fractures, abdominal pain and infections of the ear, nose and throat.

Value for money (VFM) – a term often used to demonstrate the quality of a healthcare service balanced against the cost of delivering that service.

This document is also available in other languages, in large print, and in audio format. Please ask us if you would like it in one of these formats.

Arabic:

هذه الوثيقة متاحة أيضاً بلغات أخرى وبالأحرف الطباعية الكبيرة وبطريقة سمعية عند الطلب.

Portuguese:

Este documento também está disponível em outros idiomas, em letra de imprensa de tamanho grande e em formato de áudio sob solicitação.

Bengali:

এই ডকুমেন্ট অন্য ভাষায়, বড় প্রিন্ট আকারে এবং অডিও টেপ আকারেও অনুরোধে পাওয়া যায়।

Polish:

Dokument ten jest na życzenie udostępniany także w innych wersjach językowych, dużym drukiem lub w formacie audio.

Somali:

Waxaa kale oo lagu heli karaa dokumentigaan luqado kale, daabacaad balaaran, iyo cajal duuban hadii la soo waydiisto.

Spanish:

Este documento también está disponible y puede solicitarse en otros idiomas, en letra grande y formato de audio

Chinese:

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Albanian:

Ky dokument është në dispozicion edhe në gjuhë të tjera, në format me shkronja të mëdha ose me kasetë, sipas kërkesës

Urdu:

یہ دستاویز درخواست کرنے پر دوسری زبانوں، بڑی چھپائی ، اور آڈیو طرز میں بھی دستیاب ہے۔

Farsi:

این اطلاعات در صورت نیاز به زبانهای دیگر، چاپ درشت و اشکال صوتی نیز موجود می باشند.

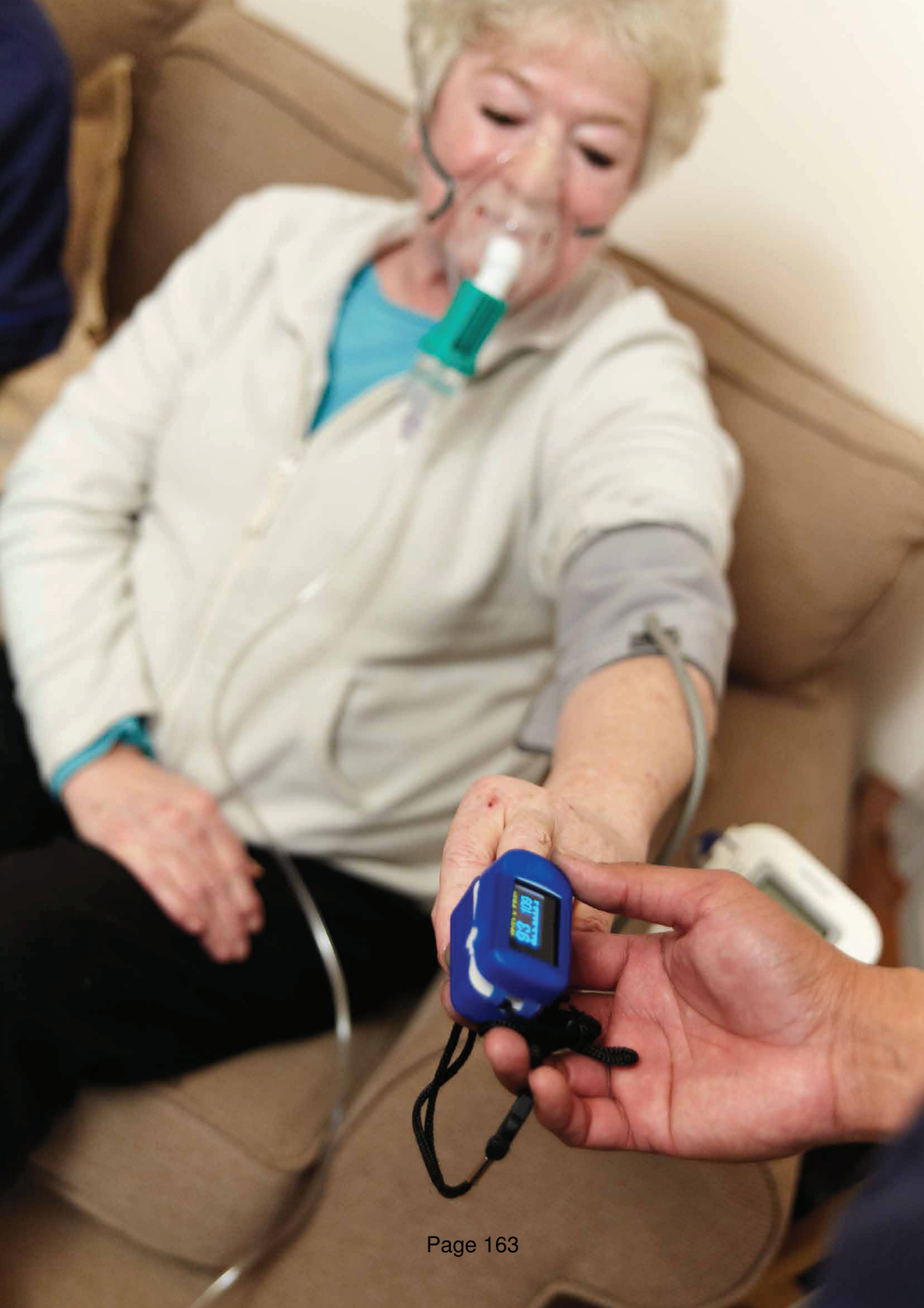
Punjabi:

ਇਹ ਪਰਚਾ ਹੋਰਨਾਂ ਬੋਲੀਆਂ, ਵੱਡੇ ਛਾਪੇ ਤੇ ਸੁਣਨ ਲਈ ਰਿਕੌਰਡ ਕੀਤਾ ਵੀ ਮਿਲ ਸਕਦਾ ਹੈ। ਇਹ ਤੁਸੀਂ ਆਖ ਕੇ ਲੈ ਸਕਦੇ ਹੋ।

Tamil:

வேண்டப்படும்போது இந்தப் பத்திரம் ஏனைய மொழிகளிலும் பெரிய எழுத்திலும் ஓடியோ வடிவத்திலும் கிடைக்கின்றது.

0800 881 5209 consultation@nw.london.nhs.uk



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	Health Partnerships Overview and Scrutiny Committee 18th July 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Brent Tobacco Control Service – Progress Report

1.0 Summary

1.1 NHS Brent has provided an update on the Tobacco Control work taking place in the borough. Three separate papers have been provided for the committee to consider and scrutinise:

(i). Tobacco Control Progress Report
(ii). NHS Brent Stop Smoking Service Update
(iii). Clear Thinking - CLeaR Model Assessment for Excellence in Local Tobacco Control - London Borough of Brent

1.2 The committee last received a report from the Tobacco Control Service in April 2011, so an update is overdue. One the committee's key functions is to consider how the PCT and council are working towards eliminating health inequalities in Brent. The work that the Tobacco Control Alliance and Stop Smoking service does contributes to this goal.

1.3 Members should note that whilst the Stop Smoking service is currently an NHS function, it is one of the services that transfers to local government in April 2013 as part of the public health transfer. Brent Council will be responsible for delivering this service as of 1st April next year.

1.4 Amanda Wilson, Brent's Tobacco Control Officer and Simon Bowen, Acting Director of Public Health, will be at the committee to present this item and answer members' questions.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to consider the Tobacco Control and Stop Smoking reports from NHS Brent and question officers on the work being done in this area.

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Progress Report for the Health Partnerships O&S Committee

Tobacco Control

July 2012

Executive Summary

The Brent Tobacco Control Strategy 2010 - 2013 was published and officially launched on 29th November 2010. The last progress report to the Health Partnerships O&S Committee was in April 2011. This paper aims to update the committee on 2011-2012 progress and plans for 2012-2013. The aim of the strategy and action plan is to reduce smoking prevalence in the borough through the following work streams:

- *Stopping the inflow of young people recruited as smokers:* 18 actions 'completed' or 'completed & ongoing', 2 actions completed but sustainability is threatened, 1 action not started.
- *Motivating every smoker in Brent to quit:* All actions either 'completed' or 'completed & ongoing'
- *Protecting families and communities from tobacco related harm*: 3 actions completed and ongoing, 2 actions in progress
- *Improving and maintaining partnership working:* All actions 'completed' or 'completed and ongoing'

Excellent progress has been made against the action plan, and 88% of the original initiatives have been achieved. However as a part of annual functionality review, the Brent Tobacco Control Alliance participated in a rigorous peer assessment process, aiming for excellence in tobacco control. This was achieved using the CLeaR improvement model self assessment template and by inviting the CLeaR team of expert peer assessors to a challenge workshop in April 2012. This provided an external perspective on progress thus far. The CLeaR report, which highlights both strengths and areas for improvement accompanies this report. Headline challenges and new work areas will include:

- Sustaining youth led interventions
- Building commitment to tackling tobacco across the council without losing the Alliance's connections with primary and secondary care
- Monitoring total spend on comprehensive tobacco activities
- Increasing supra-local working to achieve greater economies of scale in areas such as marketing, advocacy and improvement

- Development of a cross cutting communications strategy (including tobacco control website)
- Maintaining an openness and enthusiasm for change

Key Initiatives and Progress: 2011-2012

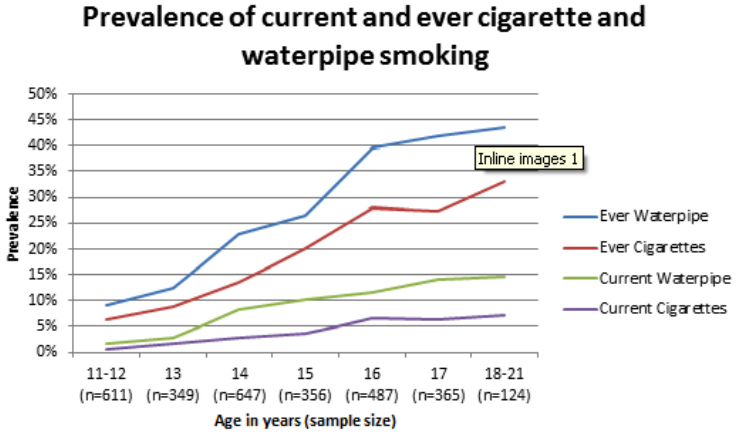
<u>Workstream 1</u>: Stopping the inflow of young people recruited as smokers

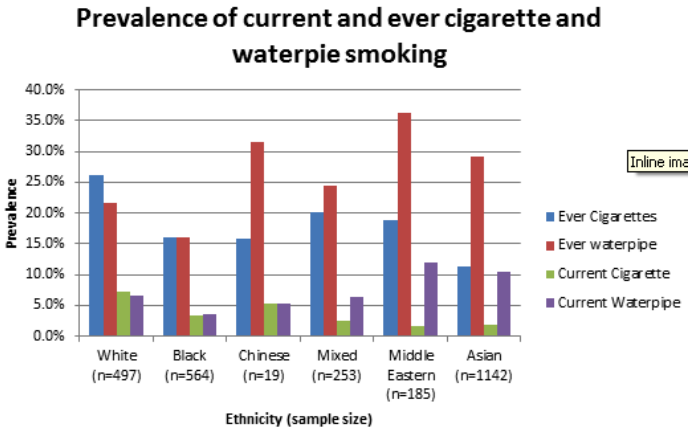
Improving the evidence base and understanding of young peoples' smoking prevalence and tobacco habits

A comprehensive body of work to better understand smoking both cigarette and shisha prevalence and attitudes among young people in Brent was conducted by Amanda Wilson and Mohammed Jawad (Imperial College), with the support of The Applied Research Unit and Health Improvement at NHS Brent and Imperial College.

- The aim was to investigate smoking (cigarette & shisha) prevalence and attitudes in Brent in addition to investigating exposure of young people to second hand smoke in the home.
- Approximately 3,000 young people in Brent (out of a possible 9,000) participated
- Validated 96 – item questionnaire
- 15 out of 22 schools approached agreed to participate
- Carried out between October 2011 and March 2012

Headline preliminary (unpublished) results for Brent, 2012:





Detailed analysis in progress. Results of the *Young Persons' Cigarette and Shisha Questionnaire* will be used both to inform future work plans and act as a baseline measure. Capacity to repeat this exercise in the future will require additional resource input.

Increasing awareness of the harms of tobacco among young people in Brent through school based and peer led initiatives

- Brent Youth Parliament in conjunction with Brent Youth Volunteers, the Brent Tobacco Control Alliance and Shishaware developed a DVD on shisha awareness called *'Shisha – Don't Be Fooled'*. This was launched at a Brent Youth Parliament session and disseminated to Brent secondary schools as a part of a bespoke shisha awareness teaching pack. This was included in a broader Smokefree Resources teaching pack, offered to all secondary schools in Brent. The DVD was also uploaded to You Tube. To date this has received 37,635 hits (www.youtube.com/watch?v=sWTgzJGzGv4).

- 14 out of 18 secondary schools in Brent accepted a comprehensive Smokefree Resources teaching pack developed by the Tobacco Control Lead, Shishaware, Brent Youth Parliament and Addaction. This also included teaching materials purchased from GASP and an exemplary whole schools smokefree policy template developed by the Tobacco Control Lead. These were delivered face to face to schools by a fixed term project officer. Delivery of the packs was accompanied by a presentation on the importance of tobacco education in schools and demonstration of the tools. Schools that received the packs made a pledge as to how they would use them. Audit of effectiveness to be conducted in 2012-2013.

- Brent Youth Volunteers ran a peer-led tobacco awareness poster competition. Youth volunteers underwent training to deliver workshops in schools to raise awareness of topics such as 'what is in a cigarette', 'why young people smoke' and 'alternative ways of spending money that an addicted smoker spends on cigarettes'. The competition attracted 101 entries over four age groups (between 5 -19) in Brent from various schools. The project provided a two-fold opportunity to up skill young volunteers and increase tobacco awareness among Brent's youth. Some comments from participants in the workshops included:

    - 'S*moking is really bad for you isn't it?'*
    - *'I'm not ever going to smoke',*
    - *'I am going to tell my friends not to start smoking',*
    - *'I think we should tell our teacher about how bad it is, she smokes you know'*
    - *'Smoking is so expensive!'*

- Funds have been secured to employ a colleague part time on a fixed term contract in 2012, whose remit will include the enhanced healthy schools model. Tobacco is one of Healthy Schools Enhanced Model named priority topics. One action that has not been delivered due to the absence of a healthy schools lead is piloting a targeted smoking cessation support in one secondary school. Data from the *Young Persons Cigarette and Shisha Questionnaire* will provide tobacco profiles for participating schools and assist in targeting an appropriate school. The pilot may include offering support to also stop smoking shisha if indicated.

- Addaction continued outreach to young people through Clinic in a Box and bespoke tobacco awareness lessons in 10 Brent schools.

Reducing Availability of tobacco to minors

- Trading Standards continued a programme of underage test purchasing for tobacco. Table 1 below outlines test purchasing results year on year. In 2011-2012, a total of 33 test purchases were carried out. 27 of these were attempts to buy cigarettes. These resulted in one sale to an under-aged person. An additional 6 attempts to buy shisha didn't result in any successful purchases, however the approach for under-age test purchasing of shisha requires re-thinking due to a number of operational constraints.

Table 1: Year on year test purchasing for tobacco results in Brent

	2010-2011	2011-2012	2012-2013
Target	57	57	45
Actual	82 test purchases resulting in 6 sales	33 test purchases resulting in 1 sale	Ongoing

Preliminary results from the *Brent Young Persons Cigarette and Shisha Questionnaire* indicate that approximately half of the respondents who smoked cigarettes stated they buy them in a café, shop or from a street vendor. Of those who bought shisha almost 75% stated they bought it from a café, shop or street vendor. Approximately 60% stated that nowadays, a shisha café is where they usually smoke shisha. These figures indicate that innovative ways of test purchasing for both shisha and cigarettes must be developed for use in 2012-2013.

- Trading Standards held 3 partnership days throughout 2011, two with Environmental Health and all three with the HMRC. 296kg of duty unpaid tobacco was seized (mainly shisha). In 2012-2013 Trading Standards have held 3 enforcement days and evenings for shisha. Only small amounts of tobacco have been seized. Vendors have been advised of their legislative duties and they have been risk rated. Cafes will receive follow up visits throughout 2012-2013.

- Trading Standards conducted a 'Statutory Warnings for Shisha Pipes' project. This included production of a 'sale of shisha tobacco advice' guidance leaflet, production of durable, wash proof labels with statutory health warnings and a letter from Trading Standards to 37 then known shisha cafes. Follow up visits were made to 25 cafes and only 5 were compliant. Follow up calls were made to the remaining cafes. Warning letters were sent again. Follow up planned for 2012.

- In 2012- 2013, seven night time operations in shisha bars to see if statutory health warnings that were previously supplied to shisha bars are being displayed on pipes as requested will be carried out. Each operation will require four officers. If possible these operations will also deliver underage test purchasing of shisha tobacco and will take note of if smoking is taking place in enclosed premises [to feed back to the shared database].

- Trading Standards conducted a proxy sales of tobacco survey, outside (not inside) shops to get an indication of how willing members of the public were to buy tobacco for young people that they did not know. 29 adults were approached and 10 sales were made. The results were forwarded via London Trading Standards (LoTSA) to the Department of Health.

- In 2012-2013, 'By Proxy' tobacco sales inside a shop in the knowledge of the sales assistant to understand if they tend to also be complicit in proxy sales will be carried out. Eight 5-hour operations each requiring four officers will be carried out.

- Trading Standards distributed LoTSA's 'Trading Standards Tobacco Control Newsletter' to over 600 retailers who sell tobacco in Brent. This magazine informed retailers to be extra-vigilant during the long school summer holidays around underage sales, raised awareness that there would be increased Trading Standards activity during this period, gave information on counterfeit products and how these affect business and advised to avoid 'single' cigarette sales.

- Surveyed 8 paan sellers to investigate sale of tobacco paan without statutory health warnings. Six were found to sell paan without statutory warnings. This resulted in 2 simple cautions; 1 prosecution and 2 with no further action due to legal complications

Workstream 2: Motivating and Assisting Every Smoker in Brent to Quit

- Brent Stop Smoking Service (BSSS) exceeded targets in 2011-2012 and progressed from being one of the poorest performing to the highest performing Local Stop Smoking Services in London in the past 12 months. Services are aligned to demand based on information from performance monitoring of providers. Significant progress has been made in developing targeted support for smokers with mental health needs, DAAT, routine and manual workers and pregnant women. Separate report attached.

Workstream 3: Protecting families and communities from tobacco related harm

Conducting Smokefree Compliance Visits

- Food Safety Team (Brent Council) continued surveillance of smokefree legislation implementation in food premises, with particular emphasis on Shisha bars. The Licensing Team also monitor smokefree compliance in pubs, clubs and venues with late night licences. Appropriate action is taken to deal with offending premises. Current statistics:

  Number of shisha cafes = 45
  Number of shisha cafes ceased trading = 11
  Number of non-compliant shisha cafes = 20

  An updated map of shisha bars and proximity to schools has been produced. Results from the *Young Persons' Cigarette and Shisha Questionnaire* suggest that current and ever shisha smoking in each school was strongly, positively correlated with the number of shisha cafes in its 0.5 mile radius. This correlation was strongest for Year 10 students, and weakest for Sixth Form students.

- Food Safety Team, Mohammed Jawad (Imperial College) and Tobacco Control Lead designed and conducted a shisha pipe sampling exercise to understand cleaning practices of shisha pipes, produce best practice guidance on how to clean shisha pipes and undertake a swabbing exercise to identify if micro-organisms are present.

Conducting Home Fire Safety Visits

- A Smokefree Homes campaign is not yet fully developed, however links are being re-established with the London Fire Brigade following their internal restructure, and verbal commitment to delivering the smokefree homes message on home fire safety visits has been agreed. The North West London Cluster is also keen to develop a region wide smoke free homes campaign which will link into this initiative. It is expected this will achieve greater economies of scale and a consistent smokefree homes message for the Outer North West London region.

Workstream 4: Improving and maintaining partnership working

Monitoring the Brent Tobacco Control Alliance through Annual Functionality Review

- Annual functionality review for 2011-2012 was conducted via participation in the CLeaR assessment model in April 2012, and consisted of the completion of a self assessment and a peer challenge workshop. CLeaR is a new approach to improving local tobacco control, specially designed for councils in England as they take on their new responsibilities for public health. The model was designed by a multi-disciplinary team of experts including NHS, local government officers, professional groups and national charities nation wide. Brent was invited to participate in both the creation and pilot of the model. Upon completion Brent received an award for Excellence in Local Tobacco Control and CleaR accreditation, including membership in the CleaR Partnership and the Smokefree Action Coalition. The full CleaR report is attached. It includes a summary of weaknesses, strengths, areas for improvement and suggested actions. More information on the CleaR model can be found at: http://www.ash.org.uk/CLeaR

Creating shared database accessible to relevant key stakeholders

- A shared database as set out in the action plan was created by the food safety team. This is held in a shared location on the Brent Council shared drive. Review of effectiveness will be carried out in 2012.

Attending sector wide, regional and national meetings/events and feedback to the Alliance

- The tobacco control lead actively participates in local, national and regional tobacco control events in the capacity of both sharing the Brent experience as well as learning from others. This has included co-chairing the London Smokefree Youth Network and attending and speaking at two tobacco control conferences throughout 2011 – 2012. Intelligence is fed back to alliance partners both on a one to one level (where appropriate) and through quarterly tobacco control meetings.

Brent Tobacco Control Strategy Action Plan 2010 - 2013

Summary Status Report on Brent Tobacco Control Action Plan – April 2012

Workstream 1 - Stopping the inflow of young people recruited as smokers

Focus Area (Key Actions)	Timeline	Lead Officer	Status
1.1 Reducing attractiveness of tobacco through both school based & peer led activities			
● Develop school lesson plans that increase awareness of harms as well as look into the social, historical economic & physical aspects of smoking & other tobacco use that appeal to young people	Sep-10	Addaction	Completed
● Integrate smokefree lesson plans into PSHE lessons at 10 Brent high schools served by Addaction	Commence Jan 2011	Addaction	Completed & Ongoing
● Promote use of lesson plans in PSHE schemes of work for remainder of schools not served by Addaction	Ongoing	Healthy Schools Lead	Completed & Ongoing
● Identify resources for Smokefree Communications & the most effective avenues for delivery in schools	Feb-11	Healthy Schools Lead	Completed
● Develop a committed team of ' Brent Smokefree Ambassadors'	Ongoing	Tobacco Control Alliance Coordinator	Completed however membership is transient & sustainability requires funding for dedicated youth lead
● Develop and disseminate tobacco awareness training (including shisha &Paan) for Smokefree Ambassadors	Jun-10	Tobacco Control Alliance Coordinator	Completed
● Conduct a debate at Brent Youth Parliament Session on youth smoking & the tobacco industry	Jun-10	Strategic Youth Engagement Officer	Completed

● Raise awareness & regular publicity of the Brent Smokefree Ambassadors through attendance at high profile events, articles in the local press & magazines and on the B My Voice website	Ongoing	Tobacco Control Alliance Coordinator	Completed & Ongoing
● Establish a smokefree youth campaign – Shisha Don't Be Fooled Campaign	Jun-11	Smokefree Ambassadors & Brent Youth Volunteers Officer	Completed
● Improve evidence base by integrating tobacco questions 'Clinic in a Box' screening tool	Quarterly reports	Addaction	Completed & Ongoing
● Use 'Clinic in a Box' screening tool to capture & monitor levels of tobacco use among 16 - 19 year olds at College of North West London	Quarterly reports	Addaction	Completed & Ongoing
● Develop an exemplary smokefree policy template for schools	Feb-11	Tobacco Control Alliance Coordinator	Completed
● Engage with 100% Brent schools to publicise, encourage & disseminate smokefree policy & link it to Healthy Schools Program	Aug-11	Healthy Schools Project Officer	Completed & Ongoing
● Offer advice to the school community on ways they can engage in activities that prevent smoking & the use of tobacco on school premises & surrounding area	Aug-11	Healthy Schools Project Officer	Completed & Ongoing
● Pilot targeted smoking cessation support in at least one Brent Secondary School	Apr-11	Healthy Schools Lead	To be started–no dedicated Healthy Schools Lead

Workstream 1 - Stopping the inflow of young people recruited as smokers (con't)

Focus Area (Key Actions)	Timeline	Lead Officer	Status
1.2 Reducing Availability of Tobacco			
● Allocate 30% of Trading Standards annual under age test purchasing target to tobacco operations	31st March each year	Trading Standards	Completed & Ongoing
● Set up pathways with partner agencies such as Environmental Health , police & HMRC to share best practice & intelligence on tobacco related activity	Aug-10	Trading Standards	Completed
● Hold at least 2 partnership days each year	31st March each year	Trading Standards	Completed & Ongoing
●Promote & market 'Shop the Shop' campaign via JC Decaux Billboard Campaign & school	May-10	Trading Standards	Completed

follow ups			
● Monitor effectiveness of 'Shop the Shop' text messaging service	31st March each year	Trading Standards	In progress
● Maintain at least 170 Responsible Trader Scheme Members in Brent & carry out compliance visits on 50% of these	31st March each year	Trading Standards	Completed & Ongoing
1.3 Reducing Affordability of Tobacco			
● Carry out & publicise enforcement action against traders who sell illicit, duty unpaid or counterfeit tobacco	31st March each year	Trading Standards	Completed & Ongoing

Workstream 2 - Motivating and assisting every smoker in Brent to quit

Focus Area (Key Actions)	Timeline	Lead Officer	Status
2.1 Improving the current Brent Stop Smoking Service (BSSS)			
● Significantly increase the number of pharmacists & GP's delivering stop smoking advice & support	Ongoing	BSSS	Completed
● Improve efficiency, flexibility, access to & capacity of core service clinics increasing the number of 4 week quits to 200 per annum	Ongoing	BSSS	Completed & Ongoing
● Empower & support inactive level 2 trained advisors in pharmacies & GP's to become active	Ongoing	BSSS	Completed & Ongoing
● Develop & monitor activity & performance of stop smoking support in secondary care pilot as per pilot evaluation recommendations	Sep-10	BSSS	Completed
● Develop, plan & action support visits to 100% of GPs & pharmacists that have signed up to the scheme	Ongoing	BSSS	Completed
● Establish registration points to recruit & register smokers into services	Ongoing	BSSS	Completed & Ongoing
● Improve capacity & capability of front line staff to identify smokers, offer brief intervention & specialist intervention	Ongoing	BSSS	Completed
● Improve administrative function to ensure all new contacts are followed up within 24 hours, & old contacts from previous campaign lists are followed up as a matter of weekly routine	Ongoing	BSSS	Completed & Ongoing
● Increase overall conversion rates of registrations to quitters from 33% to the London average quit rate of 45%	Aug-10	BSSS	Completed & Ongoing

2.2 Tackling high smoking rates in disadvantaged & vulnerable communities			
● Develop community provider & workplace schemes for contracted delivery of stop smoking support	Ongoing	BSSS	Completed & Ongoing
● Recruit champions from acute & community settings to reduce smoking rates in pregnancy	Ongoing	BSSS	Completed & Ongoing
● Provide level 1 training for midwives & contracted providers	Ongoing	BSSS	Completed & Ongoing
● Joint working with Brent Community Services developing clear referral pathways & agreed level of activity	Ongoing	BSSS	Completed & Ongoing
2.3 Delivering strategic marketing			
● Development and monitoring of a robust social marketing strategy	Ongoing	Health Promotion	Completed & Ongoing
● Delivery of weekly face to face campaigns; development of new branded marketing materials; billboard, mini-bus, Life channel and poster campaigns and other actions as set out in separate social marketing strategy	Ongoing	BSSS	Completed & Ongoing

Workstream 2 - Motivating and assisting every smoker in Brent to quit (con't)

Focus Area (Key Actions)	Timeline	Lead Officer	Status
2.4 Improving data collection and information processing			
● Monitor, review & evaluate the new SONAR information system	Ongoing	BSSS	Completed
● Establish administrative protocols to facilitate audit	Ongoing	BSSS	Completed
● Establish & implement robust performance management	Ongoing	BSSS	Completed

Work Stream 3 - Protecting families and communities from tobacco related harm

Focus Area (Key Actions)	Timeline	Lead Officer	Status
3.1 Conducting smokefree compliance visits			
● Environmental health will make at least 50 visits to shisha bars per year to ensure compliance to smokefree legislation	March 31st each year	Food Safety Team	Completed & Ongoing

● Health Safety and Licensing will continue to enforce smokefree legislation in bars, pubs & clubs as a routine element of visits to venues	Quarterly reporting	Health Safety and Licensing	Completed & Ongoing
3.2 Conducting Home fire Safety Visits			
The London Fire Brigade will conduct a minimum 2160 home fire safety visits that deliver the smokefree message every year	March 31st each year	The London Fire Brigade	In progress – not yet implemented
3.3 Delivering Public Campaigns			
● The Tobacco Control Alliance will campaign for smokefree Olympic venues in Brent for the 2012 Olympics	Ongoing	Tobacco Control Leads on Olympic Committee& regulatory services	In progress
● Alliance partners will identify opportunities & promote smokefree communities through various community and workplace events	Ongoing	Tobacco Control Alliance Members	Completed & Ongoing

Work Stream 4 - Improving and maintaining partnership

Focus Area (Key Actions)	Timeline	Lead Officer	Status
4.1 Monitoring the Brent Tobacco Control Alliance through annual functionality review			
● Annual functionality review to be undertaken in February each year	Annually in February	Tobacco Control Alliance Coordinator	Completed & Ongoing
● Action plan to be evaluated annually	Annually in February	Tobacco Control Alliance Coordinator	Completed & Ongoing
4.2 Creating shared database accessible to relevant key stakeholders			
● Creation of shared internal database that will contain profiles on all premises in breach of smokefree legislation; progress made on compliance visits; warning letters & prosecution updates accessible to relevant Brent Council departments.	Feb-11	Environmental Health	Completed
4.3 Creating clear intelligence pathways with named contact leads			
● Pathways to be set up & named contact leads communicated in order to share information both within the alliance & within neighbouring boroughs	Feb-11	Trading Standards & Tobacco Control Alliance Coordinator	Completed
4.4 Attending sector wide, regional & national meetings/events & feed back to Alliance			

● Nominated members of the alliance to attend regional, sector wide & national meetings & conferences & feed back into the current alliance monitoring & progress	Ongoing - quarterly reporting	Tobacco Control Alliance Coordinator	Completed & Ongoing

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NHS Brent Stop Smoking Service Update – July 2012

The Brent Stop Smoking Service continues to provide high quality support to motivate and encourage smokers to quit. The service exceeded the 2011/12 target of 2400 four week smoking quits. The cumulative number of four week quits was 2668.This represents 111% achievement against plan. Approximately 6000 smokers accessed the services for support.

There have been significant improvements in Brent Stop Smoking Service compared to previous years. There has been a focus on improving GP engagement and improved systems to drive up provider activity and quality. These include targeted training, robust operational processes in particular advisor support visits and lost to follow up systems.

The table 1 shows performance against four week quit targets from 2007 to 2012

Table 1 – performance against target from 2007/8 to 2011/12

Year	Target	Set quits	Nos. Quits	Conversion Rate	% of Target Achieved
2007/8	2331		188		**8%**
2008/9	1756	1735	734	42%	**42%**
2009/10	2022	3260	1183	36%	**58%**
20010/11	2360	5017	2494	50%	**106%**
2011/12	2400	5786	2668	46%	**111%**

In addition to exceeding 4 week smoking quits the Brent Stop Smoking Service in line with DH guidance and Public Health Outcomes Framework has focused on targeting priority groups of the population who are most at risk from tobacco use such as routine & manual workers, pregnant smokers and smokers with a mental health disorder. Addressing smoking cessation in routine & manual workers is key to reducing general smoking prevalence as they represent a large group within the overall smoking population.

A key success has been work focused on supporting pregnant smokers.
In Brent the rate of smoking in pregnancy has been reduced from nearly 8% in 2009 to below 3% which is a fantastic achievement.

The Brent Stop Smoking Service has a specialist midwife, who holds clinics for pregnant smokers and their partners at Northwick Park Hospital. It is important that the women understand why smoking in pregnancy is harmful to them and their babies and realise the immediate benefits when they stop Many women are not aware that cigarettes contain over 4000 chemicals, many of which get trapped by the placenta causing it to become gritty and less effective. Smoking in pregnancy can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.

Brent Stop Smoking Service has followed best practice guidelines (NICE Public Health Guidance 26) and implemented proven initiatives such as: systematic training of midwives in how to refer pregnant smokers, Offering nicotine replacement therapy (NRT) to almost all clients, having an efficient system of providing the prescriptions, providing intensive multi-session treatment delivered by a specialist stop smoking midwife, regular events and campaigns across Brent to promote the service. Brent GP and Pharmacy providers receive regular updates and training and are providing the service to pregnant women. Public Health as commissioners ensure that throughput and success rates for priority groups such as pregnant smokers are monitored and sustaining potential quits by ensuring that the most effective and evidenced based approaches such as brief intervention, individual or group behaviour therapy and NRT are used.

Crucial to Brent's success has been the strong senior leadership in NWL Hospitals who have supported and worked in close partnership with the stop smoking service to deliver a robust and evidenced based treatment programme

Local Partnership events

Brent Stop Smoking Service has initiated and rolled out a series of Partnership Events across Brent in partnership with Sexual Health and Drugs & Alcohol Services, Brent Police, Safer Neighbourhood Team, and Brent Integrated Community support from Brent Council, Hindu Council in Brent, Sai Organisation, HICC (Muslim community in Brent) and QPR**.** These events aimed at raising awareness of healthy living and promoting access to a range of services were organised in each cluster to ensure greater participation and reach of Brent residents
Carbon monoxide (CO) reading and Lung age tests were used by Stop Smoking team to demonstrate health issues relating to smoking. These have encouraged smokers to sign up to stop smoking support sessions and smokers were offered same day registrations. Free health checks comprising Body Mass Index and blood pressure measurements were also offered to the attendees.

Brent Health Partnership event: 15th February 2012
Brent Health Partnership event: 2nd March 2012
No Smoking Day: 14th March 2012 (Wembley Central Square, Kilburn Train Station, 4pm – 7pm, Brent Town Hall, Willesden Library, Harlesden High Road, Vale Farm Sports Centre, At most of the GP practices and Pharmacies in Brent)
Brent Health Partnership event: 1st June 2012
Brent Health Partnership event: 5th June 2012

Brent Health Partnership event: 6th July 2012

Forthcoming Partnership events:

28th July (Saturday), Queens Park, in the Park: Partnership Event with Met Police and Brent Council. Key focus will be to offer Child immunisation (many children centres in the area), Stop Smoking and Health Checks.

17th to 19th August (Friday - Sunday) Barham Park, Wembley: In partnership with **HICC** to support **"Eid Family Day"** in Barham Park, Wembley.

1st September (Saturday), at Willesden Sports Centre - this event is in partnership with Muslim community in Brent along with Met Police and Brent Council.

20th October (Saturday) Brent Town Hall- Armed Services support Day: organised by NHS Brent and Brent Police. All the support services to Army have been invited. **National TV has been invited to cover the event.**

National Public Health Campaigns

British Heart Foundation
BSSS worked in partnership with the British Heart Foundation holding events in Brent as part of the Red Fun February annual campaign.

COPD Awareness
BSSS takes part in the national COPD awareness event every year

No Smoking Day
Brent actively participates in the national no smoking day campaigns

Priorities for 2012/13

- Sustaining improvement
- Targeted engagement of smokers within GP practices/pharmacies
- Workplace initiatives
- Secondary Care & Community Services
- Further refinement of SONAR e.g. texting
- Continued emphasis on timely data submission
- Targeted social marketing & partnership events
- Shisha treatment programme
- Targeted support for people with mental health disorders
- Targeted support for people using DAAT services

- Managing transition to minimise destabilisation of services

CLeaR Thinking

CLeaR Model Assessment for Excellence in Local Tobacco Control

London Borough of Brent

27th April 2012

Martin Dockrell, Ghazaleh Pashmi, Alison Gardner

Brent's CLeaR scores as a % of the total available in each domain

CLeaR Context

CLeaR is an improvement model which provides local government and its partners with a structured, evidence-based approach to achieving excellence in local tobacco control.

The model comprises a self-assessment questionnaire, backed by an optional challenge and assessment process from a team of expert and peer assessors. The purpose of the assessment is to test the assumptions organisations have made in completing the questionnaire and provide objective feedback on performance against the model.

The report also provides a number of recommendations (CLeaR Messages) and the assessors suggestions for revised scores accompanied by detailed feedback on specific areas of the model (CLeaR Results). In addition we suggest some resources you may find useful as you progress your work on tobacco control (CLeaR Resources).

CLeaR in Brent

Brent Tobacco Control Alliance invited the CLeaR team to pilot the CLeaR assessment process in Brent as part of the development of the CLeaR model, and in the context of early discussions around revising and updating their tobacco plan.

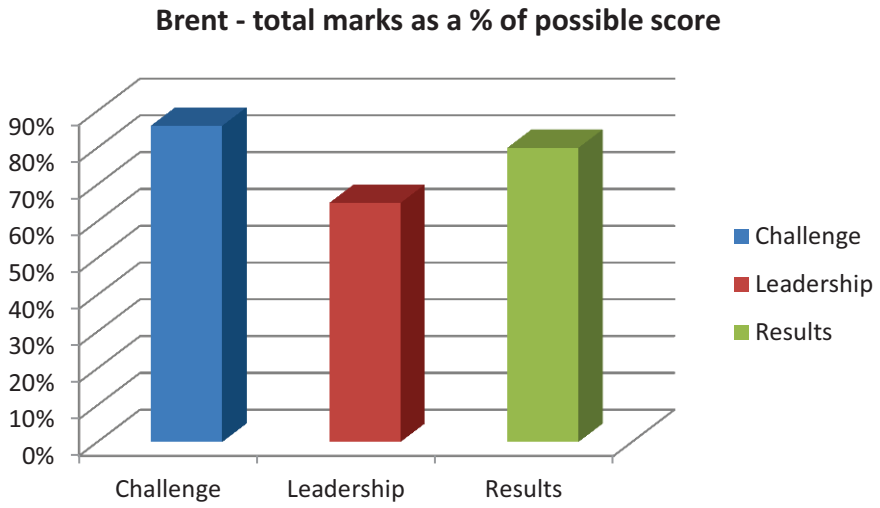
This report summarises conclusions of the CLeaR Assessment team following a workshop with members of the alliance on 27th April 2012. It sets Brent's challenge in context, providing information on the economic impact of smoking in Brent.

In carrying out the CLeaR assessment we built on Brent's own insights into areas that needed improvement, as recognised through their self-assessment questionnaire.

Special thanks go to Amanda Wilson for her assistance in responding to the self-assessment and organising the assessment visit.

Thanks also to all those who gave their time to attend and contribute to the CLeaR workshop – your lively engagement was greatly appreciated.

CLeaR Messages



CLeaR Domain	Max score	Self-assessment score	CLeaR Assessment score
Challenge Services	66	59	57
Leadership	54	37	35
Results	20	16	16

Your insights:

- The transition of public health to the local authority provides an opportunity for Brent to re-balance its programme of action to tackle tobacco, building support for tobacco control across the council and other public service partners.
- Though new governance arrangements for public health are still in development, you are currently putting building blocks in place to make strong links between the tobacco plan, JSNA and health and wellbeing strategy.
- You undertake a wide range of work on prevention of youth smoking, and the CLeaR model in its current form did not provide full scope to present this in detail.

Your strengths:

- We were impressed with the enthusiasm and engagement shown by the elected members present at the workshop, and would encourage them to champion tobacco control throughout the council, particularly as new governance and planning arrangements for public health fall into place.
- You presented innovative work looking at the prevalence of smoking and shisha amongst young people. You should ensure this is peer reviewed, to enhance your own learning, and widely shared.
- Brent takes a pro-active approach to compliance, which resists complacency and actively identifies emerging challenges.

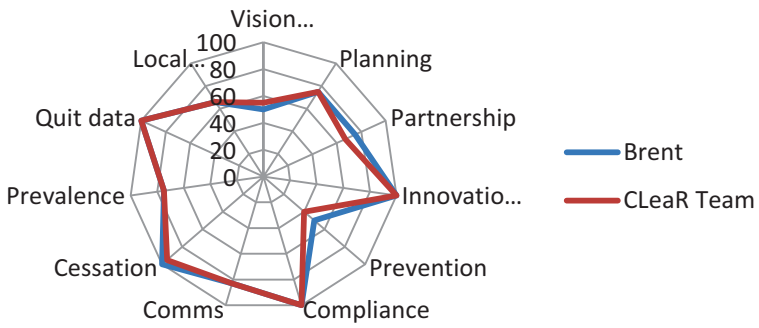
- There has been strong improvement in your smoking cessation service, delivering results that are now amongst the best in London.

Opportunities for development:

- We discussed the opportunities within transition to build commitment to tackling tobacco across the council and ensuring this is formalised within organisational strategies and action plans. This is an important step, but be careful as well not to lose your alliance's connections with primary and secondary care and community services.
- Although co-ordination of the alliance has been mainstreamed by NHS Brent, a sustained non-PAYE budget would be a wise invest-to-save measure and help maintain momentum for improvement. Youth work was another identified area where sustained funding could enable improved planning and usefully build on the innovative activity you already have in place.
- Consider monitoring your total spend on comprehensive tobacco control to mitigate the impact of any spending cuts and ensure that you achieve the outcomes you have planned.
- Further supra-local working could achieve greater economies of scale in areas such as marketing, advocacy, and improvement (for instance through the London Health Improvement Board). What could Brent do to make this happen?
- A communications strategy covering comprehensive tobacco control (as well as the stop smoking service) may be helpful in planning pro-active advocacy and communications.
- You have an active and enthusiastic tobacco alliance who are strong advocates for your work. Ensure that despite your success – "*Brilliant Brent!*" - you maintain the openness and enthusiasm for change that has helped you to improve to this point.

CLeaR Results

The chart below shows (in blue) Brent's original self-assessment scoring, as a % of available marks in each section and (in red) the CLeaR team's assessment results. Overall, the results of the peer assessment accorded closely with the self-assessment, with the CLeaR team identifying a few further areas for improvement.



Detailed comments on your assessment are as follows

CLeaR Theme	Your score	Our score	Max	Comments
Leadership				
Vision and leadership (including WHO FCTC)	9	10	18	We saw strong advocacy for tobacco amongst the elected members we met – we hope this enthusiasm will translate into sustained support and focus on tobacco control through your new public health governance arrangements, once they are in place. As you move through transition, pay attention to preserving connections with primary and secondary care and community services. The council could build on its advocacy work further by agreeing a policy in line with article 5.3 of the WHO Framework Convention on Tobacco Control
Planning and commissioning	9	9	12	We agree that increased member and management focus on performance against your comprehensive tobacco control plan (not just the Stop Smoking

				Service) could be supportive to your work – especially during transition. We recommend monitoring your total spend on comprehensive tobacco control (including partnership and in-kind contributions) A more comprehensive view of resources engaged in tobacco control could be useful to mitigate the impact of any spending cuts and ensure that you achieve the outcomes you have planned.
Partnership, cross-agency and supra-local working.	19	16	24	You achieved a lot through your full time tobacco alliance co-ordinator post. Now this position has been mainstreamed with wider responsibilities, ensure that momentum is not lost. We agree that a sustainable, flexible budget to support the work of the alliance would be a good invest-to-save measure. We saw good engagement from other council departments, this needs to be formalised more widely within organisational strategies and action plans. Brent should consider how it could lobby for supra local working to achieve further economies of scale in areas such as marketing, advocacy, and improvement (for instance through the London Health Improvement Board).
Challenging Your Services				
Innovation and learning	10	10	10	You have many strengths in this area –try to ensure that you learn systematically and consistently from your innovations.
Prevention	5	4	10	We look forward to seeing the results of your forthcoming smoke free homes programme. We accept your view that not all your prevention work was encompassed by CLeaR – but do satisfy yourselves that innovative activity accords with NICE guidance and is fully evaluated.
Compliance	14	14	14	Pro-active work on compliance and

				enforcement was a real strength, with a strong awareness of emerging challenges. Work on proxy purchasing, shisha and niche tobacco was interesting and should be shared with other boroughs.
Communications and denormalisation	10	10	12	We saw good evidence of community involvement in and through the work of the alliance. Consider a strategy to communicate and advocate for tobacco control as a whole (as well as the stop smoking service).
Cessation	20	19	20	Is there an opportunity to roll out brief advice training to a wider group of frontline employees in the local authority and other partner organisations?
Results				
Prevalence	6	6	8	Outcomes of your work to track youth smoking prevalence in cigarettes and shisha will be followed with interest.
Quit data	6	6	6	The stop smoking service is now performing to a high level.
Local Priorities	4	4	6	We support your point that as young people are a priority for you, funding for evidence–based prevention activity amongst young people needs to be sustained and protected.

CLeaR Partnerships

This section of the report summarises the feedback from the interactive session on partnerships.

You identified the following organisations as a possible source of **resources** to support your on-going work:

- London Mayors budget
- Multi-lingual resources
- Unions
- Faith groups
- Other community groups
- Councillors and MPs
- CCGs
- Research funding
- Charities
- ASH
- Tobacco control intelligence portal
- Corporate communications
- Large organisations in the private and public sector
- Tobacconists

You felt that engagement from the following **stakeholders** was important for future activity – though not necessarily through attendance at alliance meetings

- Housing
- Employers
- Children's services (facilitated through encouragement from elected members)
- Councillors (possibly using a scrutiny review to raise awareness)
- NHS primary
- Acute / mental health
- Schools
- Faith groups

You also made a number of **personal commitments** to partnership working which are included in a separate note.

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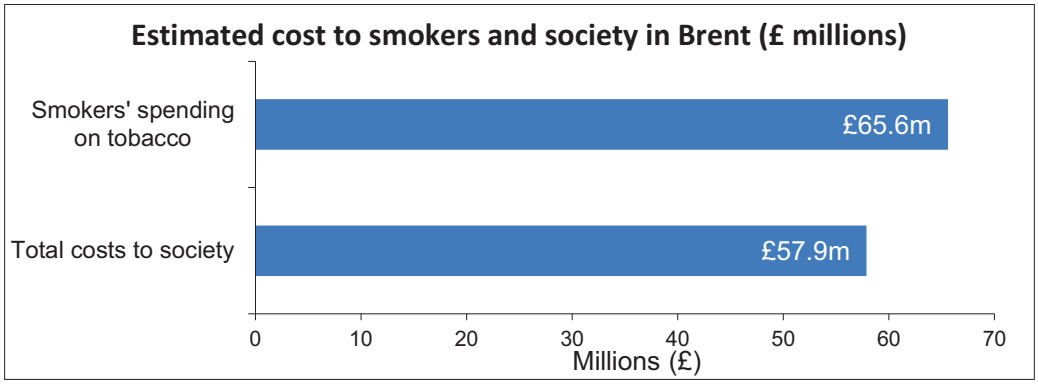
CLeaR Opportunities

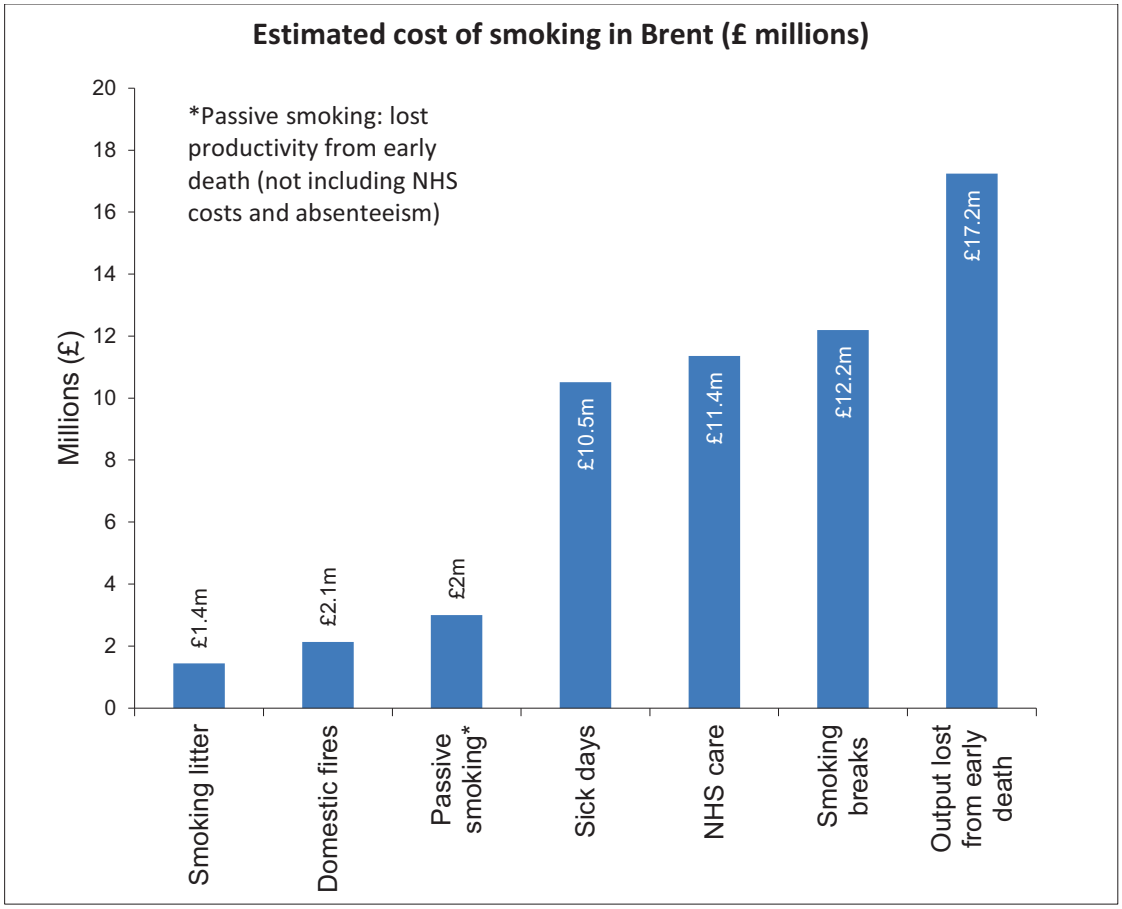
Brent's estimated (adult) smoking population is **37,100** people.

When the wider impacts of tobacco-related harm are taken into account, it is estimated that the cost of smoking to society in Brent is **£57.9m** each year. In addition the local population spend **£65.6m** on tobacco-related products.

As smoking is closely associated with economic deprivation, this money will be disproportionately drawn from Brent's poorest citizens and communities.

See www.ash.org.uk/localtoolkit/ for more details





CLeaR Resources

A briefing on investment and local authority pension funds - http://ash.org.uk/files/documents/ASH_831.pdf

NICE guidance on smoking and tobacco http://www.ash.org.uk/stopping-smoking/for-health-professionals/nice-guidance-on-smoking

Information on the business case for tobacco control, and a toolkit of resources for Directors of Public Health, local authority officers and members can be found at http://www.ash.org.uk/localtoolkit

Further local information on the business case for tobacco can be found at http://www.brunel.ac.uk/about/acad/herg/research/tobacco

The NCSCT have a range of resources which may interest you – see for instance

NCSCT Training and Assessment Programme (free) - developed for experienced professionals working for NHS or NHS commissioned stop smoking services who want to update or improve their knowledge and skills - as well as newcomers to the profession, who can gain full NCSCT accreditation.

http://www.ncsct.co.uk/training

Very Brief Advice on Smoking – a short training module for GPs and other healthcare professionals to help increase the quality and frequency of Very Brief Advice given to patients who smoke.

http://www.ncsct.co.uk/VBA

Very Brief Advice on Second-hand Smoke - a short training module designed to assist anyone working with children and families to raise the issue of second-hand smoke and promote action to reduce exposure in the home and car.

http://www.ncsct.co.uk/SHS

NCSCT Streamlined Secondary Care System (cost available on request) a whole hospital approach to stop smoking support for patients

(More information – http://www.ncsct.co.uk/delivery/projects/secondary-care - contact Liz.hughes@ncsct.co.uk)

NCSCT Provider Audit - is a system of national accreditation designed to support local stop smoking service commissioners and providers to demonstrate whether the support they provide meets minimum standards of care and data integrity. This aims to complements any existing internal quality assurance processes whilst its independent nature provides external assurance of quality and performance.

(More information - http://www.ncsct.co.uk/delivery/projects/audit-of-local-stop-smoking-services - contact Isobel.williams@ncsct.co.uk)

CLeaR next steps

Thank you for using CLeaR.

Having completed your self-assessment and CLeaR challenge workshop, you will now be awarded CLeaR accreditation until May 2014. This gives you the right to use the CLeaR logo and automatic entry to the forthcoming CLeaR awards which will be held for the first time in 2013.

In the meantime we invite you to:

- share the report with partners and stakeholders, and develop actions based on the recommendations;
- contact us if you'd like to discuss commissioning further support for tobacco control;
- take up CLeaR membership and train members of your staff as peer assessors, to enable you to participate in, and learn from, other assessments in your region;
- repeat self-assessment in 12 months time to track how your score improves; and
- consider commissioning a CLeaR re-assessment in 2014.

Contacts

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This is to certify that

London Borough of Brent

has been awarded

CLeaR

accreditation for their work to achieve

Excellence in Local Tobacco Control

Signed .....

CleaR assessors

Date May 15th, 2012

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	Health Partnerships Overview and Scrutiny Committee 18th July 2012 **Report from the Director of Strategy, Partnerships and Improvement**
For Action	Wards Affected: ALL

Kenton Medical Centre Update – For information

1.0 Summary

1.1 Members will recall that at their previous meeting the committee considered an update on primary care services in Brent, including a specific paper on the Kenton Medical Centre. Following discussions, councillors requested an update on the Kenton Medical Centre, specifically whether patients were successfully re-registering with a GP and how vulnerable patients are being helped to re-register.

1.2 NHS North West London (which is responsible for GP contract management) has provided a brief update, included as an appendix to this report. The key points in it are:

- As of 27th June 2012, 980 out of the original 2500 patients have not yet registered with another GP. These patients will be written to again to encourage them to register with another GP practice.
- There are three patients, who the practice had identified as vulnerable, who had not yet re-registered with an alternative practice. The Patient Advice and Liaison Team is in contact with those patients directly to ensure they are re-registered quickly.

1.3 This update is on the committee's agenda for information and won't be discussed in detail at the meeting on the 18th July.

2.0 Recommendations

2.1 The Health Partnerships Overview and Scrutiny Committee is recommended to note the update on the Kenton Medical Centre.

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North West London

Overview and Scrutiny Committee Paper
Closure of Kenton Medical Centre – Update

1. Background

1.1. Drs PK Das and B Das of Kenton Medical Centre gave notice to NHS North West London (NWL) on 1 March 2012 that they intended to retire from general practice on 30 June 2012. The doctors hold a Personal Medical Service (PMS) contract with NHS Brent, and own the current premises. They confirmed that the premises will not be available for use as a GP practice once they retire.

1.2. As Drs P Das and B Das are the only contractors the PMS contract terminates upon their retirement and therefore a decision must be taken on how patients will access primary medical services in the future. The practice list size at the time of the termination notice was 2500.

1.3. In light of the contract termination, NHS NWL had to determine how to proceed and identified two options.

1.3.1. Option One - enables patients to choose to register with a GP from an existing list of established practices in the area. There are five general practices within one mile and 4 slightly further away who are all accepting new registrations. Most of these practices hold contacts with NHS Harrow but this is not a barrier to patients living in Brent wanting to register.

1.3.2. Option Two - involves inviting applications from providers to take up a contract to provide primary medical services for the former patients of the surgery. There is a formal procurement process that should be followed in such cases that ensures the process of selecting a provider is fair and transparent. This procurement would be a competitive tendering exercise.

1.4. A four week engagement process was undertaken to inform patients and stakeholders of the proposed option and to ask for feedback on what information would be of use to patients in choosing a practice to register with. Six responses were received during the engagement period, these were as follows;

1.4.1. Two responses from patients were received asking for advice about how to register with another GP practice
1.4.2. One response from a patient asking for more information about the nearby practices e.g. premises access and waiting times.
1.4.3. One patient asked if patients could be automatically transferred to a GP practice of choice, instead of having to re-register
1.4.4. A GP in a Brent practice, not included in the list of nearest practices, stating that they had capacity to register additional patients
1.4.5. Barry Gardiner, Member of Parliament for Brent North, requesting

further clarification on the notice period for the practice closure.

1.5. In light of the responses during the engagement period and after reviewing both of the options in detail it was recommended to the NHS NWL Board that patients should be asked, and supported where needed by the practice and local PALs team, to register with an alternative practice in the local area, as described in option one above. The reasons for this are as follows:

- Existing GP practices in the surrounding area have capacity to register additional patients
- The list of 2500 is well below the local average practice list size and, with list inflation in Brent at around 24%; the actual list size is likely to be somewhat lower. This suggests that this is not a viable list to put out to procurement or attract sufficient interest from the market.
- It presents more individual choice for patients when choosing where they would like to be registered in future.
- As the practice premises will no longer be available for use, the availability and affordability of suitable new premises in the local area may be challenging for new providers.
- The length of time to procure a new practice and premises would be between 9 – 12 months.

Update:

1.6. Following the Board decision patients were written to informing them of the decision and sent details of other practices in the area, with their opening times, services offered and patient satisfaction survey results.

1.7. Local social services, community services and Hospital and Mental Health Trusts have been written to inform them that the practice will be closing and to ask them to support any patients on their caseloads who may require additional help in registering.

1.8. As of 27 June 2012, 980 out of the original 2500 patients have not yet registered with another GP. These patients will be written to again to encourage them to register with another GP practice.

1.9. There are three patients, who the practice had identified as vulnerable, who had not yet re-registered with an alternative practice. The Patient Advice and Liaison Team is in contact with those patients directly to ensure they are re-registered quickly.

Health Partnerships OSC

Work Programme 2012-13

Meeting Date	Item	Issue	Outcome
30th May 2012	Recruitment of health visitors in Brent	Following consideration of a report on the recruitment of health visitors in Brent in March 2012, members agreed to follow up with Ealing Hospital ICO their plans to recruit and train more health visitors in line with the Government's plans to increase the number of health visitors in England.	Members noted the number of vacancies in health visiting posts in Brent and have requested a follow up paper in six months time (November meeting) to follow up on the recruitment and retention of health visitors.
	Planned Care Initiative – ophthalmology and cardiology services in Brent	NHS Brent brought a paper to the committee in March 2012 on their plans to re-commission services for ophthalmology and cardiology in Brent. At the meeting in March 2012, members agreed to follow up two issues with NHS Brent at their May 2012 meeting: • The consultation plan for the two services • The consultancy costs associated with the retender of cardiology and ophthalmology services	Report noted, along with the concerns of Brent LINk about the consultation process.
	A&E Waiting Times in Brent	The Committee considered a report on waiting times at its meeting in March 2012. That report was missing information on A&E waiting times, and so a second paper has been requested – members have asked for a report on A&E waiting times for the committee's May meeting, and to invite representatives from NWL Hospitals to attend for this item to account for performance in A&E. The report should include information on ambulance transfers from CMH to Northwick Park Hospital.	The members noted the report and requested some additional information from NWL Hospitals: • A request for a breakdown of what happens to patients who attend A&E – i.e. the proportion admitted, treated and discharged etc. • The transfer time from ambulance to A&E – i.e. the time patients wait in ambulances

			before being seen in A&E. • Information on the longest length of time people are waiting in A&E above the four hours • Treatment times for those seen in A&E compared to those seen in the UCCs
	X-ray records at Central Middlesex Hospital Urgent Care Centre	NHS Brent is investigating a serious incident at Central Middlesex Urgent Care Centre. 6000 patients sent for x-ray but Care UK, the Urgent Care Centre provider, cannot confirm whether the radiology reports have been reviewed for missed pathology or whether discharge notifications have been issued to GPs. The committee will be presented with a report on the investigation into this incident and steps being taken to ensure that it doesn't happen again.	The root cause analysis of the incident will be presented to the next committee meeting and representatives from Care UK will also attend to answer questions on this issue.
	Primary Care Update in Brent	The committee will receive a report setting out an update on two medical centres in the borough: • Willesden Medical Centre, which is considering relocating to Willesden Hospital. • Kenton Medical Centre, which is to close	Members requested a follow up report in July 2012 setting out how many patients have been re-registered and where they have re-registered since notice was served on the Kenton Medical Centre.
	Shaping a healthier future	NHS North West London is to start consulting on plans for major service changes in the cluster. Although a JOSC has been set up to scrutinise the changes, Health Partnerships OSC will also be able to scrutinise the proposals affecting Brent. This will be standing item on the committee's agenda for the duration of Shaping a Healthier Future. Focus at this meeting will be on Brent's Out of Hospital Care Strategy.	The committee has agreed to set up a separate meeting to scrutinise the Out of Hospital Care Strategy in full and respond to the consultation. This will be done once it is clear when consultation on the strategy is to begin.

Meeting Date	**Item**	**Issue**	**Outcome**
18th July	Brent Tobacco	The committee would like to follow up the Brent Tobacco Control	

2012	Control Strategy	Strategy, to check the progress of its implementation. It is also interested in specific issues, such as the licensing of shisha bars, to see how this issue is being addressed in Brent.	
	Kenton Medical Centre	The committee has asked for a follow up report after considering the Primary Care Update in May 2012. They are interested in Kenton Medical Centre and how many patients have been re-registered, and where they have re-registered since notice was served on the practice that it was to close. NHS North West London has been asked to provide this paper.	
	Serious Incident at CMH	NHS Brent and Care UK will provide their report on the serious incident at the CMH UCC, concerning the missed pathology on radiology reports.	
	Shaping a healthier future	Members have requested information on the Shaping a Healthier Future plans for acute trusts in Brent, focussing on plans for Northwick Park Hospital and Central Middlesex Hospital, as well as St Mary's (a hospital used by residents in the south of Brent). The committee will also need to consider how it will respond to the consultation, bearing in mind the NWL JOSC.	
	NWL Hospitals and Ealing Hospital Trust merger – Full Business Case	An Executive Summary of the Full Business Case will be presented to the committee for comment and scrutiny.	
	Brent's Improving access to psychological therapies scheme	The committee has requested a report on the Brent IAPT scheme which has been in place since December 2010. Members would like the report to include information on: • How the scheme is functioning for both children and adults • The referral process • Average waiting times for treatment from the point of referral • GP attitudes to the scheme	

Meeting Date	Item	Issue	Outcome
9th October 2012	Health needs of People with Learning Disabilities	Brent MENCAP has carried out work with NHS Brent to train GPs, hospital staff and community staff about the health needs of PWLD. A report was presented to the committee in March 2012 setting out the results of the project and some of the key challenges facing those with learning disabilities accessing healthcare. It was agreed to follow up this work in Sept-Oct 2012 to look at two issues: • The NHS health check day being organised by NHS Brent, which will involve MENCAP • How MENCAP has been able to build on the initial project to train NHS staff members on working with people with learning disabilities.	
	Diabetes Task Group	The final report of the diabetes task group will be presented to the committee for endorsement before going to the council's Executive for approval.	

Meeting Date	Item	Issue	Outcome
27th November 2012	Recruitment of health visitors in Brent	At the committee's meeting in May 2012, members agreed that they would receive a progress report from Ealing Hospital ICO on the recruitment of health visitors in Brent and their progress in meeting the Government's target for health visitors in England.	

Meeting Date	Item	Issue	Outcome
29th January 2013			

Meeting Date	Item	Issue	Outcome
19th March 2013			

Meeting Date	Item	Issue	Outcome
TBC	Out of hospital care strategy	As part of the Shaping a Healthier Future work, Brent will be preparing an Out of Hospital Care Strategy. The committee will consider the strategy and respond to the consultation.	
TBC	Diabetes and physiotherapy services – plans to re-commission services in Brent	NHS Brent plans to re-commission diabetes and physiotherapy services in the borough. The committee should consider the plans for the new services, as well as the consultation plan.	
TBC	NWL Hospitals and Ealing Hospital Trust merger plans	The hospital trust merger is progressing and a Full Business Case will be available in May 2012. The committee needs to decide how it wishes to scrutinise plans for the merger, which will be built into the work programme. Follow up will also happen once the merger is approved to ensure services aren't affected during the transition period.	
TBC	Housing Advice in a Hospital Setting	Care and Repair England has produced a report on integrating housing advice into hospital services. Brent Private Tenants Rights Group would like to bring this report to the committee to begin a conversation on the best way to take this forward in Brent.	
TBC	Role of community pharmacists in improving health and wellbeing	The chair is keen to look at community pharmacists in Brent, and how their role in delivering health services can be best utilised. She also wants to look at the way that different elements of the health system, such as GPs and social care work with pharmacists in the borough.	
TBC	Mental health services in Brent	Report to committee on 29/11/11 may provide basis for further enquiries about mental health services. Chair of the committee has	

		suggested support for carers of those with mental health problems.	
TBC	Health Inequalities Performance Monitoring	The Health Select Committee should make health inequalities a major focus of its work in 2010/11. As part of this, a performance framework has been developed to monitor indicators relevant to the implementation of the health and wellbeing strategy, which relate to the reduction of health inequalities in the borough. This framework will be presented to the committee twice a year, with a commentary highlighting key issues for members to consider.	
TBC	Sickle Cell and Thalassaemia Services Report	The Committee has asked for a report Sickle Cell and Thalassaemia services at North West London NHS Hospitals Trust. The committee will invite sickle cell patient groups to attend for this item to give their views on services in the borough. This follows a previous report on changes to paediatric in patient arrangements at NWL Hospitals. Members are keen to know how sickle cell patients have been dealing with this change.	
TBC	Fuel Poverty Task Group	Recommendation follow up on the task group's review.	
TBC	Breast Feeding in Brent	Following a report in March 2011 on the borough's Obesity Strategy, the committee has requested a follow up paper on the Breast feeding service in the borough. Members were particularly interested in the role of peer support workers and how mothers are able to access breast feeding services. The committee would also like to have accurate data on breast feeding initiation and prevalence in Brent.	
TBC	End of life / palliative care in Brent	The committee has asked for a report on end of life care in Brent. Members are keen to look at how the End of Life Strategy is being implemented and to know what services exist in Brent and how effective they are in delivering care.	
TBC	TB in Brent	Added at the request of the committee (meeting on 20th Sept 2011).	
TBC	GP access patient satisfaction survey results	In December 2011 the results of the six monthly patient survey will be published. Members should scrutinise the results with Brent GPs to see how their initiatives to improve access are reflected in patient satisfaction.	

Current Task Groups

Diabetes Care in Brent – The task group is looking at services to prevent and treat diabetes in Brent and will report its findings before the end of 2012.

Future Task Groups

Female Genital Mutilation – to investigate whether this practice is prevalent in Brent, to examine the impact on victims, to see what preventative work takes place in the borough and to highlight this issue to those working with young people who are potential victims.

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