HOSC briefing session

Anne Rainsberry, Chief Executive
Dr Mark Spencer, Medical Director
Daniel Elkeles, Programme Director
29 February 2012

North West London

Welcome

Anne Rainsberry, Chief Executive

North West London

Agenda

1. Welcome and purpose of meeting

2. Update on programme since last meeting
   - Feedback from 15 February event
   - Clinical standards and service delivery models
   - Out of Hospital standards

3. JHOSC powers and remit
   - JHOSC/HOSC powers
   - Timelines
   - Principles of engagement and engagement to date

5. Discussion and next steps

Update on *Shaping a healthier future*

Daniel Elkeles, Programme Director

North West London

Stakeholder engagement event – 15 February

- More than 200 patients, clinicians and public representatives attended the engagement event at Lords Cricket Ground
- Event attendees were generally accepting of the case for change and there was strong acceptance of the clinical standards with a desire to increase their scope in certain areas
- There was enthusiasm displayed towards our plans for the transformation of Out of Hospital services with a request for further information and reassurance around their deliverability and timing
- An event report is being prepared capturing all feedback from the day and this will be used to inform the evaluation of options for change and the ongoing development of clinical and out-of-hospital standards

Stakeholder engagement event – 15 February

Feedback from patients, patient representatives and members of the public:

Patients, patient representatives and public at the morning session indicated they were pleased to be involved in the discussions at this early stage.
Main points raised included;

- Transport and access to services is a major concern
- Need for clarity about resource for the programme and £1bn funding gap
- Must be a 'real' opportunity to influence change and not a tick-box exercise
- Need for clarity around EHT/NWLHT merger and how this relates to the programme

Stakeholder engagement event – 15 February

Feedback from clinicians:

Clinicians at the afternoon session raised some concerns about the overall pace and scale of change, particularly as this is taking place through a period of transition.

They highlighted some reservations about whether proposed standards are deliverable:

- Proper integration of health and social care will need careful handling and committed joint-working; as will sharing of resources between hospital and out-of-hospital providers
- Integrated IT systems are essential in order to facilitate integrated working and this will also present a significant practical challenge.

Stakeholder engagement event – 15 February

Feedback from patients and clinicians:

Throughout both sessions, attendees emphasised the importance of integrating with other aspects of acute care, eg. mental health work, cancer services, end-of-life care. They also expressed the importance of ensuring plans are followed through in their entirety.

When looking at the evaluation criteria for the options for change, 'Quality of Care' was selected as the most important criteria by attendees at both the morning and afternoon session. This was followed, in both sessions, by 'Patient Experience'.

Clinical standards

Dr Mark Spencer, Medical Director, NHS NWL

Dr Mike Anderson, Medical Director, C&W

North West London

What has the programme done so far on acute vision and clinical standards?

- Clinical Board has agreed the vision and reviewed a long list of clinical standards, selecting the most important standards
- Reviewed service dependencies across services to design service models
- Focussed further on areas that impact the configuration of hospitals in North West London
  - Emergency Surgery
  - Maternity
  - Paediatrics (Children)
- Separate clinical groups have discussed Paediatrics and Maternity and agreed visions

The basis for our vision of care in the future

Three overarching principles underpin our vision for care		
	1	**Localising** routine medical services means better access closer to home and improved patient experience
	2	**Centralising** most specialist services means better clinical outcomes and safer services for patients
	3	Where possible, care should be integrated between primary and secondary care, with involvement from social care, to ensure **seamless** patient care

Acute visions for specific areas

A&E and Emergency Surgery

- Patients that require basic urgent care should **be able to access**, **their own GP** (if this is not feasible, through a neighbouring GP practice or an Urgent Care Centre)
- If patients need to go to hospital, they should have **quick access to high quality urgent care through an A&E** backed up by appropriate services, e.g.
  - 24/7 Emergency Surgery and intensive care
  - Diagnostic services needed to assess their condition
- Patients should be able to receive the best quality care delivered by the right person **regardless of the time or day of the week**

Maternity

Children

Acute visions for specific areas

A&E and Emergency Surgery

Maternity

- Expectant mothers should have the **choice** to deliver their baby in a hospital or in the home environment if it is appropriate
- If expectant mothers are at risk or have a complicated birth they need to have **immediate access to supporting services** such as emergency surgery, anaesthetics and other services
- Expectant mothers should be able to receive the best quality care delivered by the right person **regardless of the time or day of the week**

Children

Acute visions for specific areas

A&E and Emergency Surgery

Maternity

Children

- Parents and those responsible for children who require urgent care should **be able to access, their own GP** (when this is not feasible, through a neighbouring GP practice or an Urgent Care Centre)
- When it is necessary to go to hospital, children should have **quick access to high quality paediatric care** and care decisions should be made by a **senior and experienced** clinician regardless of the time of day or day of the week

We have been identifying clinical standards for acute care

Standards definition

- **The standards describe what we expect hospitals to deliver in order to improve the quality of care and outcomes for patients**
- **They could be related to:**
  - Clinical staff availability
  - Clinical staff level of experience
  - Patient experience
  - Volume of service
  - Etc.

Work has been conducted prior to this programme…

- **Clinical Working Groups**
  - Work in 2009/10 established a set of principles
- **Cluster**
  - Compiled list of clinical standards for certain pathways in the Commissioning Strategy
  - Identified a reduced list of standards that were core to specific pathways
  - Worked with clinicians to begin identifying standards that could be used to support commissioning on quality
- **NHS London**
  - Reviewing standards that could be used to support delivery of high quality care across London

For this work, only standards that impact clinical configuration are being reviewed

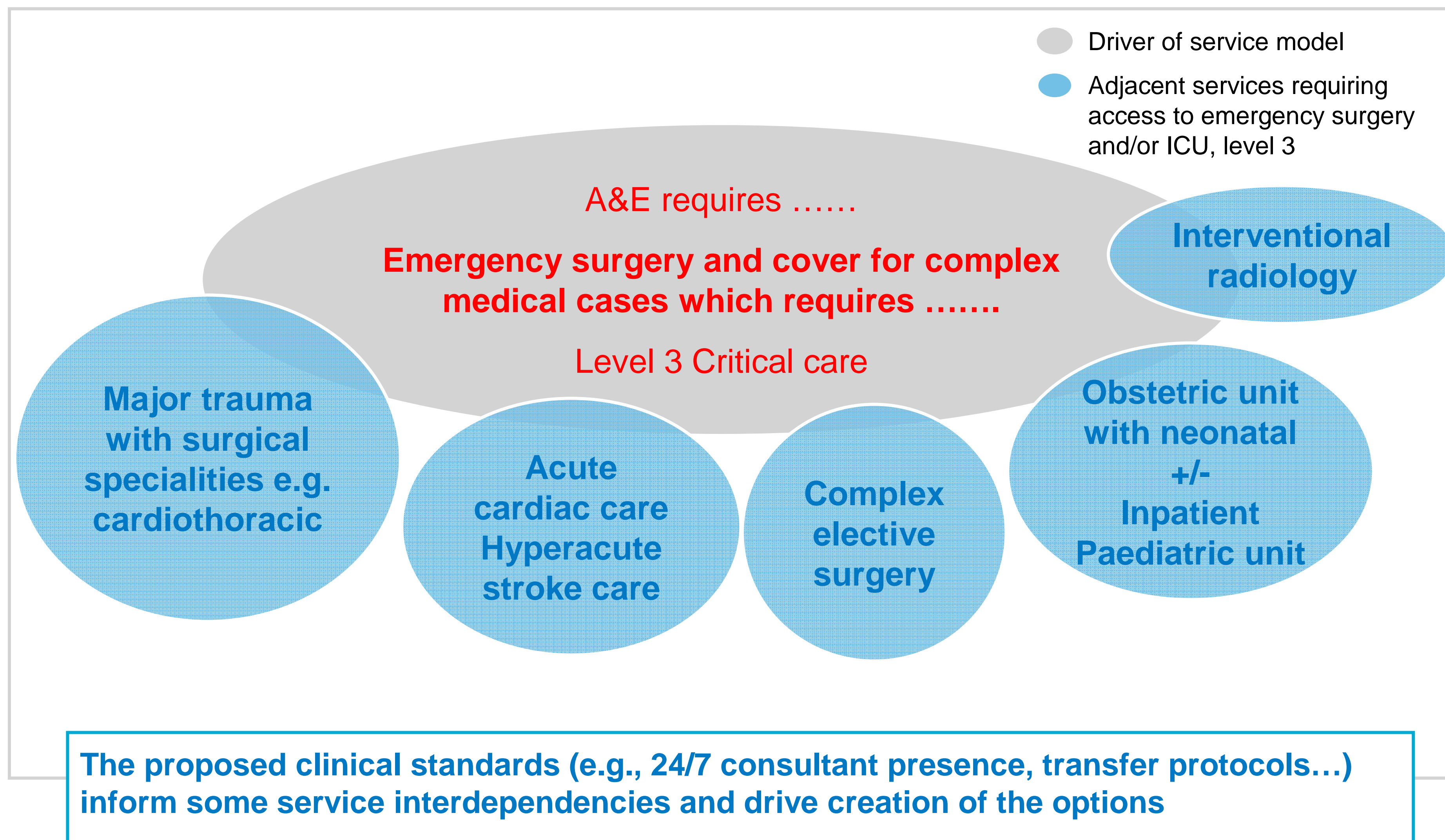
Emergency Surgery and A&E standards (1/2)

EXAMPLE

Access to Senior and Specialist Skills	
	▪ All emergency admissions seen and assessed by relevant consultant within 12 hours of decision to admit or within 14 hours of arrival time
	▪ When on-take for emergency/acute medicine and surgery, a consultant and their team to be completely freed from any other clinical duties/ elective commitments that prevent them from being immediately available
	▪ Any surgery conducted at night should meet NCEPOD 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 (e.g. laparoscopic) on site within 30 minutes, day or night
	▪ All hospitals admitting medical and surgical emergencies should have access to all key diagnostic services (e.g. interventional radiology) in a timely manner 24/7 to support clinical decision making
	▪ Single call access for mental health referrals should be available 24/7 with an aspired maximum response time of 30 mins

There is more detail on other examples in the handouts

Interdependencies between services help determine what service delivery models are clinically viable



The proposed clinical standards (e.g., 24/7 consultant presence, transfer protocols…) inform some service interdependencies and drive creation of the options

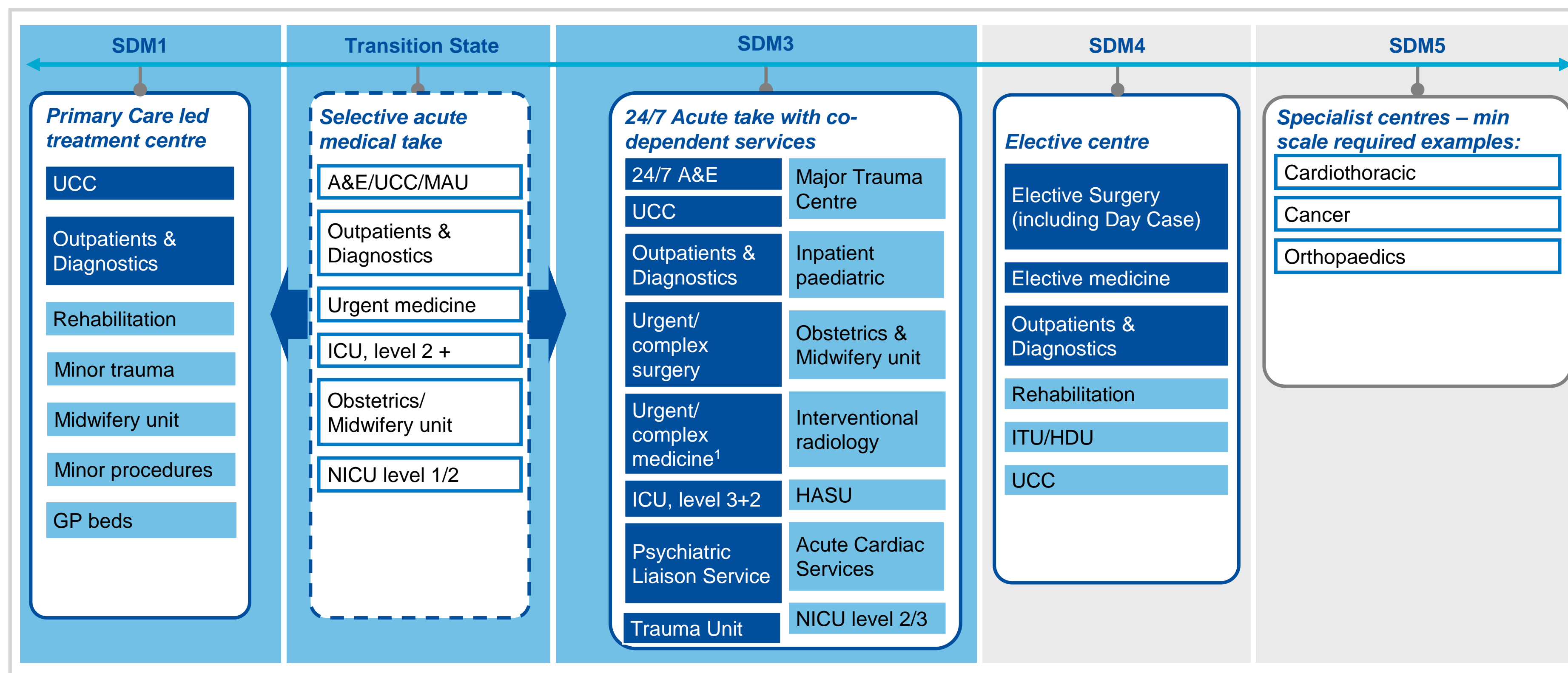
Shaping a healthier future

NHS North West London

Service Delivery Models will form the basis of viable configuration options

Optional service
Essential service

Range of services delivered in different Service Delivery Models (SDM)



Shaping a healthier future

1 Patients who have medical conditions which require a very broad range of co-located medical specialties to be managed (e.g., multi system comorbidities), or have rare or very severe forms of disease (e.g., extremely brittle asthma); also provides support for surgical patients with complex co-morbidities

NHS
North West London

Shaping a healthier future

The vision for Out of Hospital care

North West London

Background

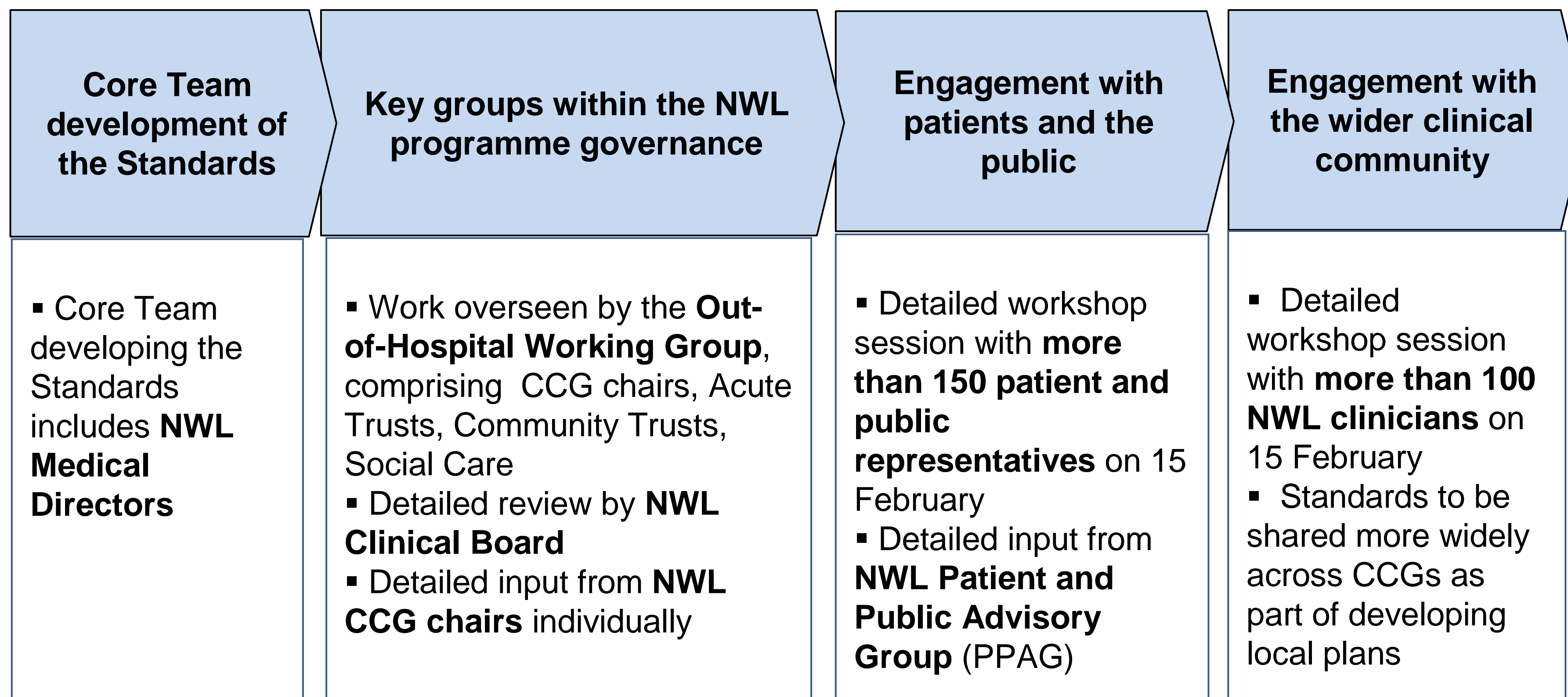
Across NWL, CCGs have identified the critical opportunities to delivering high quality and cost effective care outside of hospital to improve care for patients as well as support the wider changes required across the health economy.

The Standards support and drive the changes required to secure high quality and productive care outside of hospital by:

- Setting our **aspirations for the future** and outline the changes required over the next 3-5 years;
- Focusing on the areas that will **drive how services are delivered** by **all out of hospital providers**;
- Shifting care delivery from reactive unplanned care to **more proactive planned care;**
- Emphasising **the central role of the GP** in the coordination and delivery of out of hospital care and **going beyond current contractual obligations** of all out-of-hospital providers.

Process for developing the Standards

An iterative process has been underway to develop the Standards with a wide range of stakeholders across the health and social care community and patients and the public in NWL



Progress to date

The Standards consist of four key domains, with a total of 13 proposed standards for quality in out-of-hospital care. Detailed work is currently underway on developing metrics and a NWL patient survey to monitor performance.

Domain	Standard
Individual Empowerment & 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 & Responsiveness	Out of hospital care operates as a seven-days-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 & Multidisciplinary Care Delivery	Individuals using community health and care will experience coordinated, 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 & 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 to have online access to their health records

Next steps

Next steps focus on agreeing the proposed Standards, aligning the standards with CCG local plans for out-of-hospital care, preparing for implementation and performance monitoring

- Presentation of draft standards to NWL Clinical Board (1 March) and NWL Reconfiguration Programme Board (15 March)
- Wider circulation to CCGs and alignment with local out-of-hospital plans, including implementation and investment required (by end March)
- Development of an innovative approach for measuring performance and outcomes, including a NWL patient survey to capture feedback from individuals through a variety of channels (March-April)
- Continued engagement with key groups to ensure the Standards and patient outcomes are widely understood (March-April)

JHOSC powers

Daniel Elkeles, Programme Director

North West London

Why form a JHOSC?

- This is one of the largest reconfigurations planned in London: 8 boroughs, 2 million people, 9 acute and 5 specialist hospital sites, 423 GP practices, 2 mental health and 4 community care providers

- The plans need to be scrutinised as a cross-boundary integrated programme, and not as individual plans divided by borough or other boundaries

- Plenty of precedent in London of this working very effectively – *Healthcare for London* programme on stroke and trauma across the capital actually had a pan-London JHOSC representing all 33 local authorities; *A picture of Health* in SE London had a JHOSC representing all four boroughs

- A JHOSC is required under legislation where any proposed health changes affect more than one local authority area – it has more power than individual HOSCs and other scrutiny bodies such as Health and Wellbeing Boards and Healthwatch

What a JHOSC can do

(Health and Social Care Act 2001, Regulations 2002, Directions and Guidance 2003)

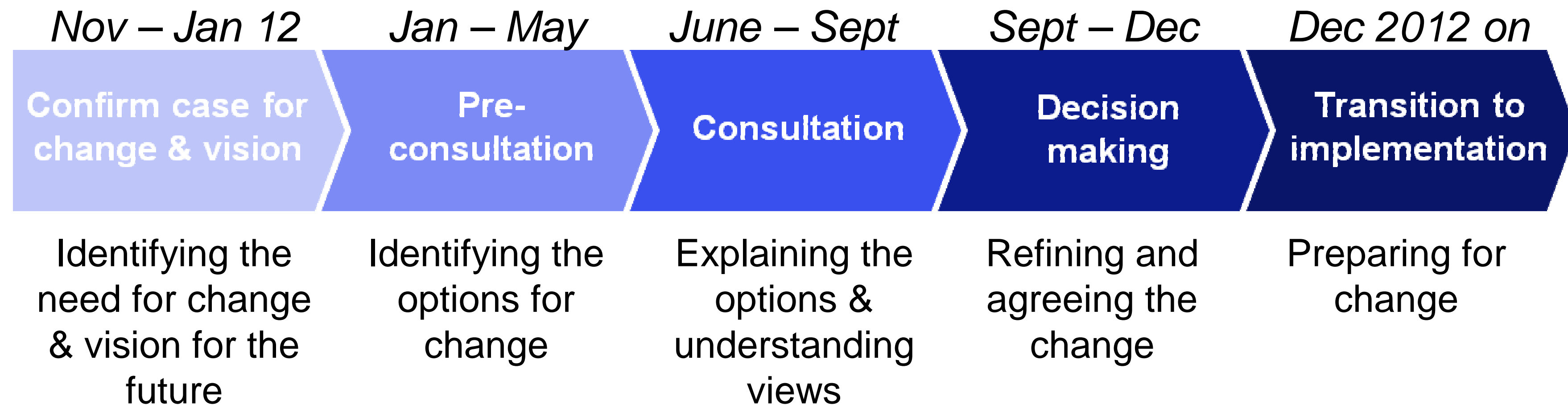
- Make comments on proposals across a wider area through delegated authority by individual HOSCs
- Require the local NHS body to provide information about the proposals in any of the 8 boroughs
- Require an officer of the local NHS body to attend to answer questions in relation to any of the proposals
- Require a response from the NHS to any queries within 28 days
- Make comments on the proposed option (s) to take to consultation and on the consultation plan, including the length of the consultation period
- Produce a single report which should aim to consider the proposals from the perspective of all boroughs affected but should aim to be consensual. This does not preclude each OSC from responding to the consultation individually
- Good practice suggests running costs are shared among all participating Local Authorities

What a JHOSC cannot do

- Undertake any functions beyond those agreed by the individual Local Authorities who appointed it
- Replace the right of individual HOSCs to refer
- Comprise members who do not reflect the political balance of the appointing Local Authorities – unless members of all authorities involved agree to waive that requirement

Programme timeline and key milestones

Our high level proposed timeline:



Next major milestone:

23 March – Second clinical and public engagement event

A chance to discuss and refine the options for change

Required timeline for JHOSC formation

- The programme timeline means that a JHOSC should ideally form as soon as possible so that there is ample time to discuss proposals as they are developed
- At the 15 March Programme Board, the ‘medium list’ of options will be discussed
- The next Programme Board meetings are on 12 April and 10 May – consultation will start in June
- The JHOSC should meet 8-10 days before each Programme Board to allow time for its comments to be taken into account and reflected in any meeting papers
- Sufficient time then needs to elapse for views on the consultation plan to be taken into account – especially on options for consultation and how these are included in the consultation document, which then needs to be printed and distributed
- This means any JHOSC needs to form **by the end of March** if its views are formally to influence the consultation plan as required in the Act

Proposed HOSC/JHOSC timeline and briefing sessions

Meeting	Date	Purpose	Proposed discussion points
Informal HOSC briefing	16 Jan *(complete)*	▪To brief OSCs on programme	▪Case for change ▪Requirement to form JHOSC
Informal HOSC briefing	29 Feb	▪ To consider outputs of 16 Feb Prog Board mtg and 15 Feb engagement event ▪ To inform Prog Bd mtg on 15 March	▪Clinical standards (inc OOH) ▪Service models ▪Process and timeline for JHOSC formation and engagement
First briefing of newly formed JHOSC	w/c 2 April	▪ To consider outputs of 15 Mar Prog Board mtg ▪ To inform Prog Bd mtg on 12 April	▪Draft short list of options ▪Benefits framework
JHOSC	w/c 30 April	▪ To consider outputs of 12 April Prog Board meeting ▪ To inform Prog Bd mtg on 10 May	▪Short list of options ▪OOH strategies ▪Draft consultation plan
JHOSC	w/c 14 May	▪ To consider outputs of 10 May Prog Board mtg ▪ To inform Prog Bd mtg on 24 May	▪PCBC / consultation options ▪Draft consultation document ▪Draft consultation plan

Engagement to date and principles

Anne Rainsberry, Chief Executive

North West London

Engagement with individual HOSCs to date

HOSC	Meeting	Notes
Kensington & Chelsea	25 JAN	Mark Creelman attended. Further information & clarification needed around the formation of a JHOSC
Ealing	26 JAN	Jenny Durandt (Ealing CCG) attended. Programme not discussed CCG Chair, Mohini Parmar, will present commissioning intentions on 8th March
Westminster	6 FEB	Andrew Pike, Karen Broughton & Mark Spencer attended Programme and requirement to form a JHOSC discussed
Brent	7 FEB	Rob Larkman and Mark Spencer attended Further clarification requested on distinction between programme and merger
Harrow	7 FEB	Daniel Elkeles attended Discussed the case for change and requirement to form a JHOSC.
Hounslow	14 FEB	Programme did not attend but now invited to attend possibly 20 March
Hillingdon	22 FEB	Mark Spencer and Nick Relph attended
H&F	22 FEB	Tim Spicer attended

Our principles of engagement

Throughout this programme, our lead clinicians and programme leaders are committed to

- **listening** to our patients and staff throughout the process
- **consulting** openly and transparently with all interested parties about our plans
- **responding** to all requests for meetings or information
- so long as those requests are **relevant**, **reasonable**, and provide us with a **reasonable timescale** within which to respond or arrange a meeting

In the specific case of HOSCs/JHOSCs

- responses are required within 28 days
- we would commit to meeting monthly and to consider any views submitted 8-10 days prior to any Programme Board meetings

Discussion / next steps

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