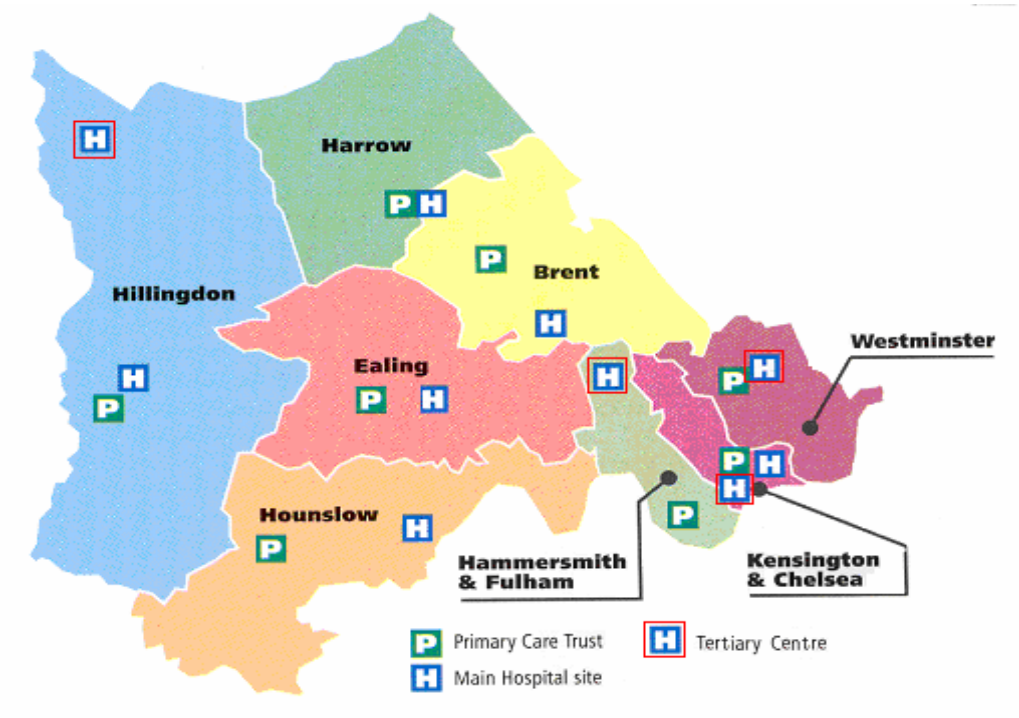
North West London Strategy Update and Next Steps



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Ratified by NWL PCT CEOs 11/05/07

1. Introduction

The purpose of this report is to ensure that all PCT Boards and NHS providers are up to date with the process for developing a coherent strategy for health and health services in North West London.

The sector has attempted to develop a strategy several times in recent years and the intention is to build on what has worked well, but to learn from what has not worked so well.

One of the lessons is that the process needs to be resilient to changes in key personnel at executive and non-executive level. Indeed since November there have been many changes to the Boards of NHS organisations in the sector. Part of the purpose of this paper is to inform newcomers of the process without losing momentum.

It is important to note that although PCTs have the formal accountability for health care strategy – very little can be achieved without mature relationships between commissioners and providers and between providers themselves. Provision for this is made in the management arrangements, particularly the Stakeholder Reference Board which has Chief Executive representation from the sector's acute trusts.

2. Overview

In November 2006, PCT Chief Executives agreed to develop a strategic programme for North West London building on the work PCTs have done individually and collectively and taking into account previous attempts to develop a coherent strategy across the sector.

It was also agreed that the approach should very much take into account local work within the sector such as: service configuration in Brent and Harrow; Foundation Trust application in Ealing; the development of a PFI in Hillingdon; the proposal for an Academic Health Science Centre involving Hammersmith Hospitals NHS Trust, St Mary's Hospital Trust and Imperial College London, and various financial recovery plans.

A key point of principle was that PCTs should continue with their local strategies and that the purpose of this approach was not to undermine local work such as Practice Based Commissioning, but to enhance it with a strategic framework and to ensure that interdependencies are addressed in a coherent way.

The work began with support from NHS London and McKinsey and activity templates were completed by March 2007. In January 2007 a Programme Director was appointed and a meeting structure put in place to support the process (see below).

Since November 2006 a number of major issues have emerged which have reinforced the need for this approach:

- *Healthcare for London: A Framework for Action* (Ara Darzi's review across London) is gaining significant momentum and providing a useful London wide context for the sector
- Guidance has been issued by NHS London for PCT Commissioning Strategies and, importantly, for sector wide strategies. North West London is working to an accelerated timescale for the production of a sector wide strategy by the end of June.
- Consultation on the proposed Academic Health Science Centre has begun. This is a tremendous opportunity for North West London which requires a strong strategic commissioning framework. A paper of commissioning issues that need to be considered as part of the development of the AHSC is attached as Appendix 1.

2.1 Context

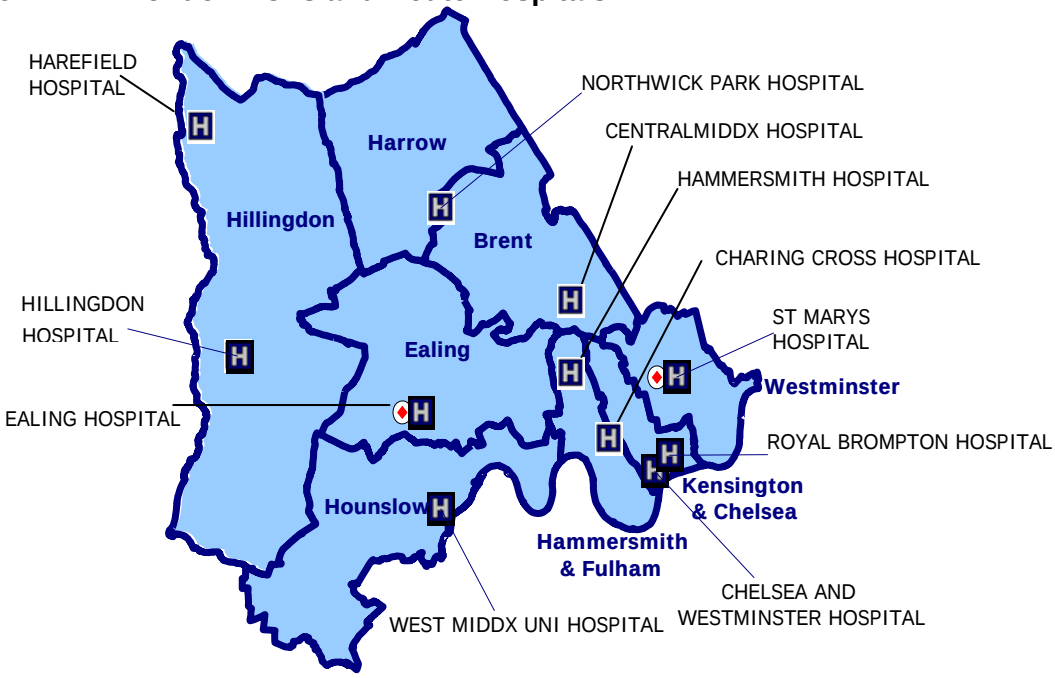
NWL serves an ethnically and culturally diverse population (Table 1). It has some of the most ethnically diverse wards in the country - around 35% of the local population belong to ethnic minority groups. For example, Brent has the highest "non-white" proportion and Asian communities account for more than a quarter of the population in Ealing, Hounslow, Brent and Harrow. NW London is also characterised by areas of great affluence alongside significant deprivation.

Table 1 – NW London Demographics

	Westminster	Kensington & Chelsea	Hammersmith & Fulham	Ealing	Hounslow	Brent	Harrow	Hillingdon
Population 2006*	247,551	186,814	183,733	324,094	214,492	264,339	231,798	273,953
Ethnicity 2006**	31.74	21.62	24.33	43.09	37.87	55.54	40.94	20.65

*Source: ONS Population Projections 1998, ** Source: London Research Centre 1999 Round-based projections (v99 P1)

Figure 2 – NW London PCTs and Acute Hospitals



The health system in North West London is highly complex – ranging from small GP practices providing primary care locally to major teaching hospitals conducting cutting edge specialist research and treating patients from across the country. There are 8 acute trusts, eight PCTs and two mental health trusts serving a population with a wide range of health and social care needs.

There have been several reviews of services in NWL, the most recent, 'Our Healthy Future' which began in 2005. This work builds on previous work and will ensure that robust, well evidenced commissioning plans are the basis for strategic decisions about healthcare delivery in the future.

2.2 The London wide review

The London-wide review has been set up to look at the following issues:

- **The need to improve Londoners' health**
  One Londoner dies every hour from a smoking related disease. Rates of childhood obesity are higher than the rest of England. Obesity counts for 4,000 deaths in London each year. 57% of England's HIV cases live in London. One million Londoners have had mental health problems.
  Changes could improve the quality of life for people with long term conditions and save lives through prevention rather than cure.

- **The NHS is not meeting Londoners' expectations**
  27% of Londoners are dissatisfied with the running of the NHS (compared to 18% nationally). Londoners are less satisfied with GP services than people nationally.
  Changes could please more of the people more of the time.

- **One city, but big inequalities in care**
  Londoners do not experience equity either in terms of their health outcomes or in terms of the services they receive. NHS funding per person varies greatly across the capital. In general, there are fewer GPs in the areas with the greatest health need. Hammersmith and Fulham has twice the proportion of smokers of Harrow.
  Changes could reduce the inequality across different parts of London.

- **The hospital is not always the answer**
  Medical and scientific advances mean treatments which once required several days in hospital can now be completed and the patient return home the same day. In some cases, treatment can now be provided from GP surgeries and health centres rather than hospital.
  Changes to community based NHS services could prevent people needing hospital treatment.

- **The need for more specialised care**
  London has many excellent hospitals, but in some specialist areas we are not providing care to nationally recommended standards, for example, stroke patients should get a CT scan within 3 hours, but only seven London hospitals currently scan 90% of their stroke patients within 24 hours.
  Changes could save more lives and help Londoners make better recoveries from serious illnesses.

- **London should be at the cutting edge of medicine**
  Healthcare begins in the science labs. There are good examples in other countries where medical research universities and hospitals working more closely together leads to benefits for local patients.
  Changes could help the NHS to provide a truly world class health service to Londoners

- **Not using our workforce and buildings effectively**
  The NHS has never employed staff in a way which makes it easy to move between hospital and community settings. There needs to be more support for staff to work more flexibly to deliver the best care.

  NHS buildings in London cost £0.7 billion just to service, and the maintenance estimate to bring London hospitals up to an acceptable standard is over £800 million.
  Changes could improve both the care available and the environments in which it is provided.

- **Making the best use of taxpayer's money**
  Funding is not the major reason for change but money wasted through inefficiency in one aspect of healthcare is money that could have been used to save lives elsewhere. Unprecedented national growth in NHS funding will slow down from April 2008, so it will be more important than ever to reduce inefficiencies and use every pound to maximum effect.
  Changes could improve efficiency and release millions of pounds to be used to further improve services.

2.3 North West London

In addition to the London wide perspective, NWL PCT Chief Executives agreed the following national and local drivers for change that are affecting health services in North West London:

- **Patient Focussed Services**
  Patients prefer services to be as local as possible and to be treated by the right person in the right place at the right time. In North West London there is evidence of an over reliance on hospital emergency services in the past which could be addressed if the community and primary care services were in place as an appropriate alternative.

- **Centres of excellence**
  As technology advances and consultants increasingly specialise in areas of medicine and surgery, it is imperative that the most up to date standards can be met. To enable doctors to keep and improve their skills they need to treat patients regularly Centres of excellence, supported by appropriate transport and community services can ensure this[i].

- **Recruiting and keeping staff**
  Suitably qualified staff are essential to providing high quality services. It is expected, as we compete in an increasingly competitive market for staff, that building centres of excellence in all aspects of health care will help this.

- **European Working Time Directive**
  In 1972 doctors could work 120 hours a week with little sleep. The working time directive means that no staff can work more than 56 hours a week. This is a positive step forward in terms of safety but does mean more doctors are needed to cover rotas. We now need about 3 times as many doctors as in 1991.

- **Better use of resources**
  Services in North West London are not sustainable in the long term – more money is being spent than is available on services that are not delivering the best for patients. Investment in hospitals has always been higher than investment in community services and that is not necessarily the way to ensure high quality modern services.

- **Guidance and policies**
  There is a plethora of national policy and guidelines that will influence how services need to develop in North West London. The key ones are the National Service Frameworks that describe what patients should expect from various treatment pathways, the White Paper 'Our health, our say, our care', the Cancer Plan, the NHS Plan detailing wide ranging plans for the quality and responsiveness of services and work of experts such as George Alberti, National Director for Emergency Care, who has produced a report on the need for change in the way emergency care is provided[ii].

- **Poor quality buildings**
  Some buildings in the sector have significant backlog maintenance issues with an estimated cost of £345million to achieve appropriate standards of healthcare accommodation. Healthcare facilities in much of North West London are in very poor condition – over half of them were built before 1948 and less than a quarter are under 20 years old.

The agreed criteria that will inform how the programme moves forward are:

- The proposals must have clinical support
- The proposals must be sustainable
- They must be compliant with national policy
- They must be low-risk in terms of knock-on impact to other parts of London's health services
- The proposals must have commissioner support
- Due process must be followed in developing the proposals
- The proposals must be capable of demonstrating to the public and their representatives that they will receive safe, accessible and high quality services

Mental Health services will be considered as they form part of both commissioning plans and trusts' services but this is not a full review of mental health services. The PCT Chief Executives are committed to developing a strategic approach to commissioning mental health services, but this is likely to go beyond the timescales mentioned here.

3 Work so far

3.1 Programme Board (CCG)

The Programme Board was established late in 2006 and is comprised of PCT Chief Executives and others as necessary and is authorised to take decisions to allow progress of the project but is not authorised to take decisions on which scenarios proceed to final consultation as individual boards will have to consider this. The programme board can discharge its responsibilities through the normal powers delegated to Chief Executives and through the formal arrangements already developed for collaborative commissioning. Andrew Morgan (Harrow PCT Chief Executive) and Mike Wood (Hammersmith and Fulham PCT Chief Executive) are the sponsors of the NWL strategy.

3.2 Stakeholder Reference Board

The Stakeholder Reference Board is comprised of PCT and NHS Trust Chief Executives and others as necessary (eg a local authority representative and project lead for the AHSC) and is the main forum for developing mature relationships between commissioners and providers and between providers themselves (obviously notwithstanding well developed local relationships with local PCTs).

3.3 Clinical Reference Group

The Clinical Reference Group (Chaired by Dr Stephen Jefferies and made up of PEC Chairs, Acute Trust Medical Directors and commissioning leads) has been meeting every fortnight since February and has moved forward significantly. The Clinical Reference Group has been focussing on clinical quality.

The areas identified by the clinical group are:

- **Unscheduled care** – The focus, so far has mostly been on making Accident & Emergency (A&E) departments work more efficiently through target setting and other initiatives. A&E attendances are considerably higher than the UK average and numbers are continuing to rise. The majority of the conditions people present with could be dealt with by their GP and his/her team. We want to ensure people have easy access to NHS care, but that they are being seen by the most appropriate people to help with their problem.

- **Long Term Conditions** – People with incurable conditions such as diabetes need on going support from the NHS. With the right help they can live relatively healthy and independent lives. Without the right help they can be in and out of hospital with deteriorating health and a much poorer quality of life. We want to make sure services are organised in a way which diagnoses problems quickly, supports people to live independently, and provides the best specialist care when people need it. Currently services for these patients in NW London are inconsistently organised and too many patients have to be admitted to hospital when their conditions are exacerbated, rather than problems being prevented before they occur.

- **Standardising Clinical Practice** – At the moment people with the same condition living in different parts of North West London are treated differently and some patients are required to attend hospital more frequently without receiving any improvements in their care by so doing. We want people across the area to be treated equitably.

- **Specialist Acute Services** – Acute is 'NHS speak' for very serious conditions that need to be seen in hospital. Relatively few people need this level of help, but when they do their lives may be at risk. We want to ensure specialist acute services are organised in a way which maximises the number of people who survive and make an effective recovery.

- **Paediatrics** – Specialist healthcare for children in North West London is currently too fragmented. We want to ensure paediatric services are organised in a way which achieves the best clinical results for sick children.

- **Obstetrics** – Pregnancy and childbirth services need to be available 24 hours a day, with consultants always on hand to deal with complications. We want to ensure obstetric services are organised to provide consultant cover at all times. Birth rates are increasing (12.5% in North West London in the last 6 years) so it is important that we plan services to meet the growing demand.

In response to a number of comments from stakeholders, it is recommended that a specific stream of work under the heading Improving Health is pursued.

3.4 Stakeholder and PPI reference group

The NWL Patients Parliament is keen to be fully engaged in supporting the work of the NWL Strategy. They have identified members who would like to act as a sub-group to support the work and believe that they could engage with their network to local groups to ensure robust engagement.

A document has been produced that will form the basis of the initial conversations and a plan to ensure that there is a consistent approach across the sector in terms of the questions asked of local people.

An initial meeting has also been held with the West London Alliance (council leaders) and they understand the case for change and are keen to be involved to ensure appropriate solutions.

The discussion process will also involve the specialist clinical networks.

At this stage, open discussion with the public and stakeholders is regarded as good practice (too often the NHS has approached the public too late to allow a genuine co-production of the available options and the more formal consultation process).

3.5 Task and finish groups

Will be established as necessary.

3.6 Governance

This strategy is likely to result in significant changes in the way healthcare is provided in North West London. The Programme Board, which owns the project, will oversee the development of the discussion process, and the proposals themselves and evaluate their fitness prior to consultation. They will work through the various groups with a clear and transparent process and, following a period of engagement, work with stakeholders to select hopefully a range of viable options which will be publicly consulted on.

This consultation will be led by PCTs and exactly how that is organised and supported will depend on the nature of options being consulted upon and will be finalised as the strategy develops.

If necessary, a joint overview and scrutiny committee will be established to act, in accordance with sections 7 and 8 of the Health and Social Care Act 2001 and associated regulations and guidance, as the statutory consultee for the NHS public consultation on the future of health services in NW London.

PCT CEs have decided to develop a stream of work specifically related to the governance arrangements for decision making should substantial service change be necessary. This will explicitly include how practice based commissioning will be accommodated in this process. It is anticipated that this piece of work should be completed by September.

4 Next steps

Good progress has been made to date, but to ensure that momentum is maintained the programme needs to be ramped up significantly over the next few months. It is accurate to say that strategy is every PCTs core business – however, the reality is that in order for PCTs to fulfil their core business, additional infrastructure is needed in the short term and the PCT Chief Executives have agreed that resources need to be made available.

In February 2007, Sir Ian Carruthers published *Service Improvement: Quality Assurance of Major Changes to Service Provision*. The relevant recommendations from his review of how best to engage public and clinical support for service change are as follows:

- Reasons for change should be built on a clear evidence base of clinical and patient benefits. The case for any change needs to be stronger and better articulated. Recent Tsar reports make it clear that major service changes are first and foremost about saving lives;

- Clinical and staff involvement in developing proposals is critical; more needs to be done to engage clinicians, staff and their representatives in the process at a local, regional and national level;

- Good preparation and understanding the process (pre-consultation, consultation and implementation) is crucial; there is a wide variation in quality and fitness of proposals;

- Strong coherence and co-ordination of local proposals is essential; some areas have clear strategies, in others the approach lacks cohesion. PCTs should be at the centre of major service change, driving service improvement where appropriate; and

- Communications need to be strengthened; consultation documents should contain specific, relevant, clear information written in plain English for local stakeholders to comment in an informed way on local proposals.

All the PCTs therefore need to ensure that we adhere to these principles.

Next Steps 'at a glance'

April – October – Discussion (pre-consultation) process underway in individual PCTs, needs to be enhanced sector wide. Engagement with the public will continue over the summer and will change its focus as more specific issues emerge from the collaborative work.
Workshop events will also be held with PCT Boards, NHS Trust Boards, Local Authorities and other stakeholders.

May – 'first cut' advice from the Clinical Reference Group for consideration in commissioning strategies

June – PCT Commissioning strategies, and sector wide CCI derived from local priorities and sector wide work, including the advice of the clinical reference group, and from *Healthcare for London*.

July – consider the options for revised commissioning arrangements to ensure the AHSC operates within a strong commissioning framework

July – October – Translation of PCT Commissioning strategies into plans for the next 3-5 years – some will be uncontroversial (eg replacement of primary care buildings) – some may require full and formal consultation and will be prioritised on the basis of clinical priority and common sense.

September – October – Generate the options for major service change (if required) according to clinical priority.

October (if needed/ready) – PCTs sign off options and process to go forward to consultation.

With regard to timescales, again one of the lessons of from previous strategies is that 'false deadlines' can be extremely damaging. Therefore, the PCT Chief Executives wish to reserve their position on actual timescales and proceed on the basis of *commonsense and clinical priority*. Nevertheless, it is the judgement of the PCT Chief Executives that for the reasons outlined above, our objective should be to have options for major service changes developed by the autumn.

North West London PCT Chief Executives
May 2007

[i] Professor Roger Boyle, National Director for Heart Disease and Stroke, Department of Health 2006, *Mending hearts and brains; Clinical case for change* London: The Stationary Office

[ii] Sir George Alberti, National Director for Emergency Access, Department of Health 2006, *Emergency Access: Clinical case for change* London: The Stationary Office

APPENDIX 1

The North West London Strategy for Health
Academic Health Sciences Centre
Key Messages from a PCT perspective

Purpose of this Document

The purpose of this paper is to provide the wider strategic context which PCTs would like to see addressed in the proposal to create an Academic Health Science Centre. It highlights a number of areas the commissioning PCTs would like to see explained in the public consultation material.

Future service change

Whilst the proposed consultation will only cover institutional, rather than service change, It is important to recognise that the AHSC proposal is part of a wider ongoing discussion about the future of health services in North West London.

The PCTs, as the commissioners of the services of the new organisation, would like to see the consultation address how an AHSC could support and promote new models of care which will meet the NHS objectives of:

- providing more health improvement/preventative support;
- enabling more self management of health;
- increasing patient choice; and
- bringing appropriate services out of hospitals into community and primary care settings
- a clinically and financially sustainable health care system

The timing of the proposal to create an AHSC is excellent given the London wide review and it is essential that the AHSC consultation addresses the points highlighted in *The Case for Change* published by the Framework for Action review group.

PCT Commissioning strategies

The PCTs in North West London will be completing their Commissioning Strategies in spring 2007. These will be set within the context of a strategy for NW London. These strategies will be subject to public and stakeholder involvement and where specific major changes are proposed there will be full and formal public consultation. While each commissioning strategy will uniquely reflect the requirements of each PCT, it is expected that the themes outlined below will hold true across the whole of NW London. The AHSC consultation should include reference to a need for services to meet the needs of local populations, as defined by the PCTs responsible for commissioning the healthcare for those populations.

The PCTs and other NHS organisations have agreed to co-operate across NW London to ensure that there is a clinically and financially sustainable system for this sector of London.

High ambitions
While the ambition for the Academic Health Science Centre is to be recognised as one of the world's top academic health centres the consultation must clearly show how the AHSC believes residents of NW London will benefit from having such an institution on their doorstep. In particular how benefits would be seen by a large proportion of the population and not just a limited number receiving highly specialised care.

To achieve this vision the AHSC will need to be:

- providing the highest quality healthcare to our local communities;
- a world leader in patient care, research, education and training;
- a place of discovery and innovation;
- a diverse community of the world's most talented people dedicated to the improvement of human health;
- a driving force in local and national economies

As commissioning PCTs we share the vision to create a world-class organization recognising the potential benefits of providing even better healthcare services to local residents. To succeed we believe the AHSC will have to work closely with the broader health community in NW London to ensure that the role of the AHSC complements that of the district general hospitals and primary care trusts. How an AHSC would complement existing NHS services in NW London (hospital and primary/community services) should be made clear in the consultation.

It is of course fundamentally important that the ambitions of an AHSC could be delivered in the context of a financially sustainable system. The AHSC proposal needs to demonstrate that it would be a positive force for change and could make a significant contribution to delivering a clinically and financially sustainable healthcare system in which its services are as efficient as best international practice and affordable in the context of the full range of healthcare services needed in NW London and London as a whole.

As far as possible service models will be tested against international best practice for evidence of effectiveness; value for money; and patient satisfaction. The aim also is that they will be "future-proof", so that models of care developed now, will still be safe and appropriate in 10-20 years time.

Commissioning Assumptions
The need to modernise many of the current models of patient care in NW London is being driven by the following assumptions and hypotheses:

- That services in the NW London area are not keeping pace with public expectation; developments of new drug and therapeutic regimes; new technological advances; investment opportunities and further potential for research and development.

- That there are a series of changes happening in the way we can, in future, support patients to manage their own health; to make choices about the type of treatment that best suits their condition and to have world class treatment when needed.

- That world class research, development and teaching, led in this case by Imperial College, will ensure that patients will benefit from better and earlier diagnosis and better clinical outcomes for their condition in the proposed new Trust and/or through better support to patients and their GPs and other clinicians based outside of hospital.

- That despite major investment of public funding over recent years, too much money is tied up in buildings and in duplication of services rather than in the delivery of care and that this is hindering our ability to invest in new services based in primary care and new drug and treatment regimes in secondary and tertiary care.

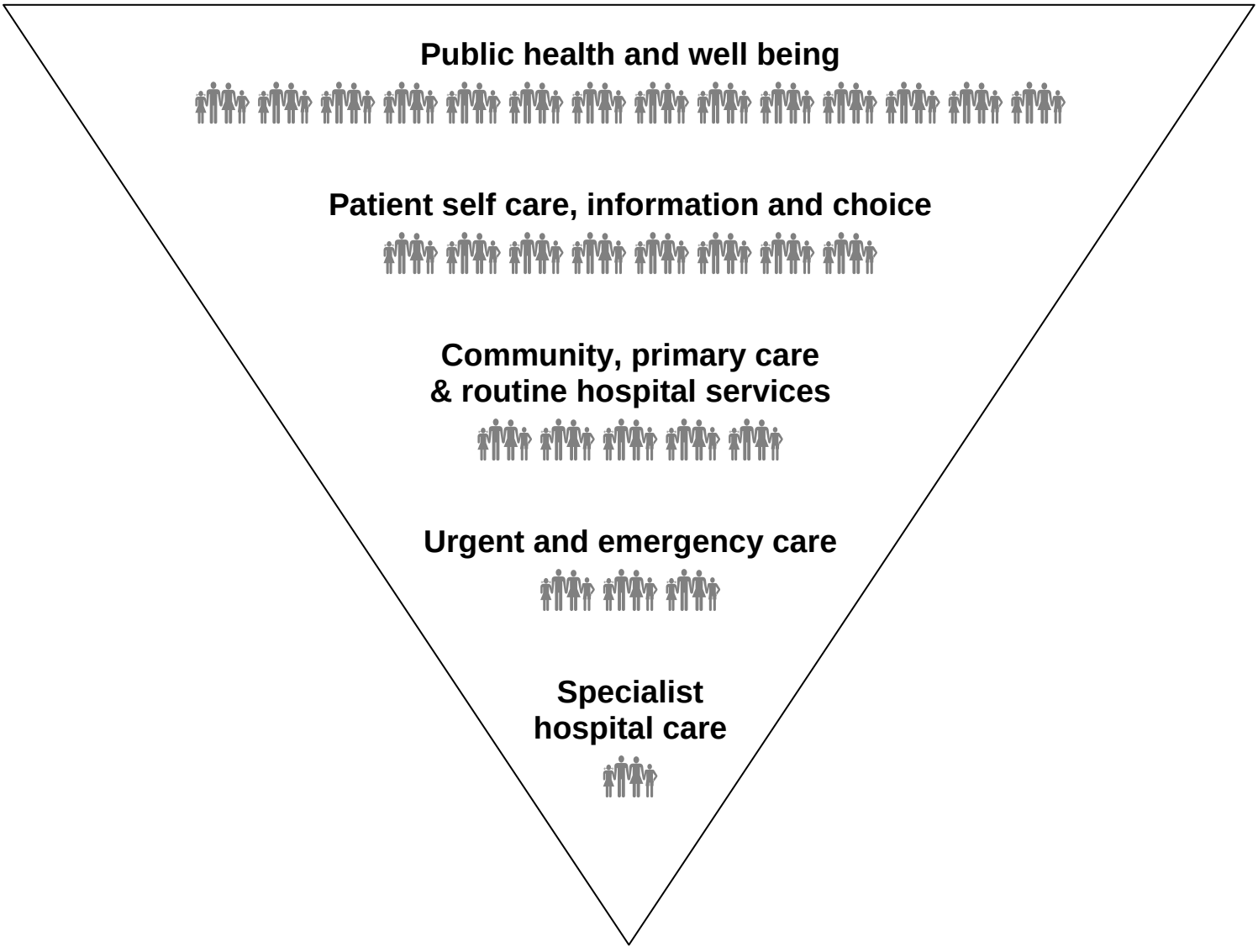
The consultation needs to explain how the creation of an AHSC would support/address these assumptions.

Partnership opportunities
The proposed merger creates a unique opportunity for all the sponsors and major stakeholders to commit to working together on developing new models of care over the next ten years. The consultation needs to recognise this opportunity and address the potential benefits of a new spirit of partnership between the commissioners, on the one hand, and those providing health and science based services on the other, all equally committed to finding the best value from public money for the public good.

Shape of health care for the future

The diagram below shows the whole picture of healthcare which Primary Care Trusts must consider and commission services for. At the top of the triangle, Public Health issues such as nutrition and exercise affect everybody within a PCT. At the tip are very specialist services for rare conditions which affect only a very small number of people.

The consultation needs to show how each level in the diagram below could benefit from the creation of an AHSC or recognise areas which it may not be possible for the AHSC to influence



The following pages look at each of the levels within the diagram above.

1. Public health and well being
The majority of residents in NW London will rarely (if ever) need to be treated in one of the hospitals which would be part of an AHSC. However, PCTs must support the health and well being of all their residents, providing services which not only help treat illness but also support healthy people to remain so.

Many determinants of health and well being are outside the direct control of the NHS, with factors like education, employment, housing having a fundamental impact on people's health.

The consultation should address how an AHSC could benefit the public health of residents in NW London. This should include the potential from a research and treatment perspective and also possible benefits of local regeneration in and around the sites owned by the organisations which would form an AHSC.

2. Patient self-care, information and choice
People can take many positive steps to keep themselves as healthy as possible (eating healthily, exercising more, stopping smoking and so on).

PCTs also plan to extend and invest in a range of services which aim to keep people healthy and reduce the need for people to attend hospital, these include:

- Expert Patient Programme
- Personal health programmes).
- Pharmacy led minor ailments schemes
- Healthy schools programmes
- Voluntary Group led health information and advice

The consultation needs to address if/how the creation of an AHSC could support the development of greater self management and provision of health information to support people in making healthy choices.

3. Community, primary care & routine hospital services

PCTs plan to develop more community based services, bringing appropriate services out of hospitals and into GP surgeries and community health centres. The aim will be to offer an extensive range of treatment and diagnostic services in the community, so people only have to go to hospital when it is absolutely necessary. For example, the creation of GPs with Special Interests means GPs are increasingly referring patients to another GP for treatment which in the past was only available in hospital.

All the primary care trusts (PCTs) in North West London are investing money in updating community facilities. Many of these facilities will be able to support a much wider range of services than those traditionally offered in the community. The consultation should address what kind of services the hospital trusts believe could be transferred to community settings in the future and how the creation of an AHSC might speed up this process. In some cases teams currently based in hospitals may be able to work from community

settings, but the consultation should also address the potential to transfer skills from hospital based specialists to general practitioners and other community based staff.

The consultation must also emphasise that routine hospital care for more common conditions will not lose out and that a greater focus on research and innovation will not be limited to highly specialist and rare conditions.

Long term conditions including coronary heart disease, diabetes, asthma, stroke, high blood pressure, chronic obstructive pulmonary disease (COPD) and epilepsy affect relatively large numbers of people and the consultation should address how an AHSC could bring improvements in the care (both inside and outside hospitals) available to people with these conditions. Focus should be drawn to any potential to support:

- Early diagnosis
- Early treatment
- Improved health
- Greater independence

4. Urgent and unscheduled care

Emergency or unplanned care is currently provided by a wide range of different services, including primary care out-of-hours services, emergency mental health teams, ambulance services, NHS Direct and Accident and Emergency departments. A lot of work has already been done to link unplanned care and the consultation needs to address how the creation of an AHSC would further this work.

The majority of patients who attend A&E departments actually need “primary care” i.e. they do not have an immediate life threatening condition. The consultation should address how an AHSC could support changes to A&E services to meet the needs of patients in a more clinically and financially appropriate way.

5. Specialist hospital care

Some patients may already know about the concept of ‘centres of excellence’ offering very specialised care at a single regional centre. If the trusts proposing to merge believe that it is likely a merger would result (at some stage in the future) in specialist services developing in a reduced number of centres of excellence this should be made clear in the consultation with the rationale and potential benefits of centres of excellence highlighted. It is, however, also important that the consultation stresses which hospital services will ‘stay local’.

The consultation should refer to the Case for Change report to support the justification for centres of excellence. However, all patients need to be assured that access to services locally is not being cut and if they have a rare condition or one which needs specialist expertise then their local hospital is part of a specialist network which will provide the best care from the most appropriate setting.

The consultation should also address how an AHSC may benefit NW London residents through the opportunities of more clinical research trials and product development happening locally.

Delivery of hospital services based on the best available evidence
PCTs wish to accelerate progress in delivering services to the standards based on the best available evidence. PCTs would expect the AHSC to demonstrate its capacity and capability to respond to this agenda.

Priority areas (not exhaustive) are:

- The proposed AHSC should work with commissioners and other North West London providers to ensure the Improving Outcomes Guidelines for Cancer are implemented.

- The proposed AHSC should work with commissioners and other North West London providers to ensure appropriate 24 hours cover and support (eg vascular surgery) to trauma centres and Polytrauma services (the work by Professor Ara Darzi is recommending on trauma centre to population of 1.5 million. NW London is 1.7 million).

- The proposed AHSC should work with commissioners and other North West London providers to ensure appropriate Cardiac services – ensure appropriate access to primary angioplasty. The AHSC should work with commissioners and other North West London providers to ensure appropriate Consider the appropriate utilisation of the assets to reduce delays.

- The proposed AHSC should work with commissioners and other North West London providers to ensure appropriate Paediatric services – reducing variations in the quality of Paediatric Intensive Care and Neonatal Intensive Care to reduce fragmentation of specialist services .

- The proposed AHSC should work with commissioners and other North West London providers to ensure appropriate standardising clinical practice – referral guidelines for GPs and consultant to consultant, follow up ratios, excluded procedures, thresholds for surgical intervention and for emergency admissions to be agreed.

- The proposed AHSC should work with commissioners and other North West London providers to ensure appropriate Stroke – services to be configured so that stroke patients are seen by a specialist within one hour of arrival in A&E, have a scan within 3 hours and are on a specialist ward within 4 hours

Releasing resources by reducing duplication
The proposed merger of the two Trusts would lead to opportunities to improve quality and make savings by focussing some specialties on one site rather than two. This is an area where patients will have concerns because it may lead to longer travel times Whilst the consultationmust put across a clear clinical case for creating centres of excellence on a single site it should also be open about the potential savings.

This consultation must make it clear that any such changes would be subject to future consultation and specific changes would focus on tangible patient benefits such as (i) improved outcomes; (ii) reduced waiting times for access due to greater efficiency; (iii) improvements to the patient journey through reducing the internal waiting times and delays between different parts of the internal system; and (iv) releasing funds tied up in supporting two separate departments only a few miles apart for frontline care such as new drugs or new treatments.

In tandem with the PCTs supporting the partners in a programme of internal Trust changes to improve operational efficiency, the sponsors will make a joint commitment to a five year programme of services, which will be moved off the hospital site – and back to their GPs for ongoing care. This would be described in more detail by an annual plan of these services, which, with the right education and support could, on a rolling programme – to be carried out either by the patients own GP or by another health professional operating on their behalf.

The consultation must make it clear that the two Trusts will continue to provide, between them, the full range of local services which local people can reasonably expect from a London teaching hospital. Sub-specialisation at tertiary care level and the use of applied research and development is part of supporting local acute services and not an end in itself.

The AHSC should also be able to demonstrate opportunities for new inward investment from the commercial sector.

Key messages
The consultation on creating an Academic Health Science Centre should cover the following issues:

- **How will an AHSC contribute to improvements in services across all levels of care for local residents? (shown in the diagram on page 4)**

- **How will an AHSC support the provision of more healthcare in primary care and community settings to reduce the need for people to be admitted to hospital?**

- **How will an ambition to be one of the world's best healthcare institutions improve care for local residents in NW London?**

- **How will an AHSC support the need to ensure London's NHS services as a whole are clinically and financially viable?**

- **How will residents who currently have specialist services in their local hospital benefit from the potential creation of centres of excellence in hospitals further from where they live?**

- **It is fully understood that the AHSC consultation is about organisational change and that any proposed chagnges to services will be subject to further full and formal public consultation in line with the NHS and Social Care Act.**

Lynda Hamlyn / Mike Wood
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