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Brent

Health Partnerships Overview and Scrutiny Committee

Wednesday 4 December 2013 at 7.00 pm
Boardroom - Brent Civic Centre, Engineers Way, Wembley, HA9 0FJ

Membership:

Members Councillors:	**first alternates** Councillors:	**second alternates** Councillors:
Daly (Chair)	Mitchell Murray	Moloney
Hunter (Vice-Chair)	Sneddon	Brown
Colwill	Baker	Kansagra
Harrison	Singh	Naheerathan
Hector	Aden	Al-Ebadi
Hossain	Ogunro	RS Patel
Leaman	Green	Clues
Ketan Sheth	Gladbaum	Van Kalwala

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democracy.brent.gov.uk

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 1 - 10

4 Matters arising (if any)

5 Health Services: Winter Provisions 11 - 66

The Health Partnerships Overview and Scrutiny committee may remember that last winter (2012/13) North West London Hospitals Trust's Accident and Emergency Departments struggled to cope with the additional pressures traditionally felt during the winter months. Brent CCG and NWLHT have therefore both been asked to provide the committee with details of their plans to cope with the forthcoming winter pressures.

6 Brent CCG "Wave 2" Commissioning: Impact Assessment and Consultation Plans 67 - 84

Brent Clinical Commissioning Group is about to undertake "Wave 2" of its procurement plans. The CCG will be using consultants Mott MacDonald to undertake both an impact assessment and the statutory consultation for this procurement and the proposals for both of these are now being presented to the committee.

7 NW London Hospitals: 18 Week Referral to Treatment Targets Incident 85 - 100

The reports from North West London Hospitals highlights the fact that, in February this year, it was identified that 60% of patients on the waiting lists did not have an open care pathway, meaning that waiting times had been wrongly recorded and that, as a result, large number of patients had been waiting longer than 18 weeks and there was an unmanageable number of cases on the waiting list that could not be addressed through normal channels.

8 Update on Plans for Central Middlesex Hospital 101 - 114

Brent CCG, in conjunction with the North West London Collaboration of CCGs, has been asked to provide an update on the plans for Central Middlesex Hospital which will now follow as a direct consequence of the Shaping a Healthier Future plans.

9 Health Partnerships Overview and Scrutiny work programme 2013-14 115 - 118

The work programme is attached.

10 Date of Next Meeting

The next scheduled meeting of the Committee is on 28 January 2014.

11 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.

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.

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Brent

MINUTES OF THE HEALTH PARTNERSHIPS OVERVIEW AND SCRUTINY COMMITTEE
Tuesday 8 October 2013 at 7.00 pm

PRESENT: Councillor Daly (Chair), Councillor Hunter (Vice-Chair) and Councillors Colwill, Hector, Hossain, Leaman and Ketan Sheth

Also present: Councillors Cheese and Hirani (Lead Member for Adults and Health)

An apology for absence was received from: Councillors Harrison

NHS representatives present: Tina Benson (Director of Operations, North West London NHS Hospitals Trust), David Cheesman (Director of Strategy, North West London NHS Hospitals Trust), Mark Creelman (Brent Customer Account Director, North West London Commissioning Unit), Rob Larkman (Chief Officer, Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Group), Ethie Kong (Chair, Brent Clinical Commissioning Group), Sarah Mansuralli (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) Jo Ohlson (Chief Operating Officer, Brent Clinical Commissioning Group), Julie Sands (Deputy Head of Primary Care – North West London, NHS England) and Ian Winstanley (Assistant Chief Operating Officer, Brent Clinical Commissioning Group)

Brent Council officers present: Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement), Toby Howes (Senior Democratic Services Officer, Legal and Procurement), Phil Porter (Interim Director, Adult Social Services) and Melanie Smith (Director of Public Health, Adult Social Services)

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

None declared.

2. **Minutes of the previous meeting held on 24 July 2013**

RESOLVED:-

that the minutes of the previous meeting held on 24 July 2013 be approved as an accurate record of the meeting, subject to the following amendment:-

- Page 1, under ‘Also present’, add ‘Councillor Hirani (Lead Member for Adults and Health).

3. **Matters arising**

Brent Clinical Commissioning Group: commissioning intentions

In reply to queries from Members, Rob Larkman (Chief Officer, Brent, Ealing, Harrow and Hillingdon Clinical Commissioning Groups) confirmed that a list of consultees for cardiology and ophthalmology procurements and a copy of the Brent

Clinical Commissioning Group (CCG) investment study had been provided to the Committee.

4. **GP and Primary Care Access and Service Provision**

Julie Sands (Deputy Head of Primary Care, North West London NHS, NHS England) introduced the first report on access to primary medical services in Brent. She informed the Committee that the national GP patient survey 2012-2013 had been analysed to identify what areas were in need of improvement. In Brent's case, there had been a considerable variation in GP practices across the borough in relation to patient access, both in terms of practice opening times and in how patients rated access. This was an issue that was mirrored across England and was of some concern. Julie Sands advised that the national Assurance Framework, developed by NHS England, bought together a range of demographic and performance issues about practices, including reported patient satisfaction on accessing GP services, and this information would be used to identify and manages practices where there were concerns about the level of service provided. NHS England would carry out an investigation into the underlying reasons for any concerns or dissatisfaction with a particular practice and depending on the circumstances of each case, the course of action to address this may involve encouraging best practice with other high performing practices in the locality, taking remedial action or in more serious situations or where the problems had continued in the longer term, using contractual levers such as breach notices and control sanctions.

Referring to the Standard General Medical Services Contract in the second supplementary agenda, Julie Sands advised that this was nationally prescribed. However, there was no specific criteria in respect of access provision. Members noted that there was a range of different kinds of contracts that the provider may have with the NHS, however every effort was made to encourage practices to offer enhanced services, although this was optional. Members noted the types of contract and the services offered by each practice in Brent as set out in the first supplementary agenda.

Jo Ohlson (Chief Operating Officer, Brent CCG) then presented the second report on supporting practice improvement and primary care development that detailed the outcome of the Access Choice and Experience (ACE) programme and the work of Brent CCG since April 2012. An update on the outcome of patient satisfaction rates was also included, comparing results with 2009/2010, 2010/2011 and 2012/2013 respectively. It was noted that the biggest improvement in Brent was satisfaction in being able to get through to a practice by phone. Jo Ohlson advised that there had also been some improvement in being able to obtain an appointment reasonably quickly. However, in respect of satisfaction with the opening hours of GP practices, this had seen a slight reduction and this mirrored the trend nationally.

With regard to Brent CCG support to improving care, the following strategies had been developed to underpin this:-

- Supporting development and implementation of practice improvement plans
- Investing in additional primary care capacity
- Transforming primary care as part of developing out of hospital services

Jo Ohlson explained that Brent CCG worked with practices to ensure that they were fully compliant with their improvement plans when they registered with the Care Quality Commission in April 2013. The CCG had also invested £500,000 per annum for 2012/2013 and 2013/2014 to improve practice premises in areas such as control of infection and accessible premises for people with disabilities. In order to increase capacity and patient satisfaction, Brent CCG was commissioning additional bookable appointments via a patient's GP practice in five locality centres on a pilot basis for six months and involved GP and nurse appointments availability between 15:00 and 21:00 hours Monday to Friday and 09:00 to 21:00 on Saturdays. In addition, members heard that there were a number of work streams to develop out of hospital services, including identifying the need to create locality centres in Kingsbury and South Kilburn. It was noted that NHS England had already approved funding for a locality centre in Kingsbury. Jo Ohlson added that Brent CCG was working with the support of the North West London Strategy and Transformation Team to develop an outline business cases for Central Middlesex Hospital (CMH) to be a hub plus for primary and community services, including specialist diagnostic services, outpatients and GP services and for Wembley and Willesden Centres for Health to be hubs with extended community services. The eight North West London CCGs were also developing outcomes and standards that all out of hospital providers would be required to meet and these would complement standards in the national contract.

Members then discussed the item and raised a number of issues. A member commented that although there had been some improvements in the most recent survey compared to previous surveys, there remained considerable variation in patient satisfaction of GP practices, including within a particular locality. She sought further details as to what levers and sanctions could be used, including where there had been breaches of contract. Another member commented that as hospital services were being reduced, GP practices should be offering more services and she asked for the most recent data on the uptake of the pilot scheme in some practices offering additional appointments with GPs and nurses. Confirmation was sought that all Brent GP practices were subject to the Quality and Outcomes Framework and when would the Primary Care Assurances Framework apply. In respect of performance, details were sought on the number of practices in Brent identified as poor performers and what action had been taken to date to address this. Furthermore, it was enquired whether poor performance could often be attributed to poor leadership. It was also asked whether single partner practices were more likely to be performing poorly than larger practices. A member asked how performance was being benchmarked with other local authorities. In respect of the patient survey, it was asked how difficult it was to take resultant action because of the level of robustness of information that had been obtained from it.

A member referred to appendix two of the report, covering additional enhances services being offered by GPs, and expressed concern on the lack of practices providing services for diabetes, especially as this condition was relatively high in Brent and she asked for an explanation as to why this was the case. She also felt that the lack of practices making claims in respect of cardiology services was not encouraging. Another member noted the lack of practices offering psychological therapy services and enquired whether they were being encouraged to opt in to this service. Another member commented that with the additional pressure on GP practices following changes to the NHS and the commissioning being undertaken and the reduction in budgets for services such as cardiology, what action was being

taken to ensure improvements to services in such areas. Confirmation was also sought in respect of the variation of charges for ECGs and the reasons for these, particularly as the fees for ECGs undertaken by hospitals was considerably higher than those done by GP practices.

In reply to the issues raised by members, Julie Sands advised that the practice contracts does not specify particular targets but states that practices must meet the reasonable needs of patients and show evidence of this. Where practices appear to be under performing, NHS England investigates the reasons for this and also draws on other information, which if revealing serious issues, provides it with greater leverage to take action. Where practices have been identified as having some weaknesses, initially a remedial notice that would include an action plan would be issued. If this did not address the issue or it was more serious, then a breach of contract notice would be issued, or, in the most serious of situations, the contract could be terminated. However, in the majority of cases, practices responded positively in working to address concerns and collaborate with NHS England to achieve desirable outcomes. Practices were also encouraged to consider alternative ways of providing services in order to facilitate improvements, such as using other technologies to be accessible to patients, including e-mail. Members noted that the programme of action for those practices identified as having some concerns had recently commenced and the first practice would be visited this week.

Julie Sands advised that eight practices had been identified as first priority for the need for action, with a further six practices categorised as second priority. In the past, there had been a correlation between poorer performing practices and smaller practices, however this was not so apparent now and indeed there were some larger practices in North West London that were having difficulties. Julie Sands advised that there had been some changes to the patient survey since the initial one in 2009, with the language softened to encourage responses, although this sometimes led to more vague feedback. She informed members that comparisons between practices in Brent and with other London boroughs could be provided, adding that sharing data between practices with similar demographics would be particularly useful.

Julia Sands confirmed that practices in Brent had been subject to the Quality and Outcomes Framework since 2004. The Primary Care Assurances Framework had been published in May 2013 and was in the process of being rolled out across England.

Jo Ohlson advised that the pilot scheme offering additional appointments had started in September and the data from the first week had shown an uptake of between 30% and 50%, although nurse consultations had a lower uptake that those with GPs. As a result, the possibility of offering nurse consultation up to two weeks in advance and sharing nurses across practices was being looked at. Jo Ohlson added that selected practices from Wembley and Kingsbury localities had commenced the pilot scheme this week and the initial data for this would be provided to Mark Burgin (Policy and Performance Officer, Strategy, Partnerships and Improvement). The committee heard that the practices who were participating in the pilot scheme were not receiving additional funds, so it would be difficult for them to employ more staff to help them offer services for the extra hours provided.

Jo Ohlson advised that Brent CCG was working with the practices identified to seek improvements and the concerns raised were not generally attributable to weak management. Many practices also faced especially challenging circumstances and patient satisfaction with access did not necessarily correlate with the opening hours as some areas were more demanding than others. Members noted that there were no shared patient records between practices and their hubs and there was also variation between how each locality transferred this information. In respect of funding reductions for some specialist services such as cardiology, Jo Ohlson stated this may result in the reduction of follow up appointments in some cases, however she informed members that she would seek more information on this and respond to this query. With regard to diabetes services, Jo Ohlson explained that the role of GP practices was primarily to identify the condition and refer accordingly, rather than provide on-going clinical support and a number of practices in Brent already provided this. Diabetes services remained available in hospitals and because of the rise of this condition in Brent, consideration would be given to expanding the service in this setting. Members heard that the claims submitted from practices as detailed in appendix two were from quarter one of 2013-2014 and a number of practices had submitted claims since then. Whilst practices may want to offer particular services, sometimes this was not feasible due to capacity limitations and it was part of the commissioning teams' role to provide practices the appropriate support.

Ethie Kong (Chair, Brent CCG) emphasised the importance of working with patients to improve access to services and of being sensitive to the needs of the local community. She advised that some practices were unable to offer ECGs so would refer patients to a hospital whose fees are higher. However, investment and training to provide ECGs was available for practices and if they already had the necessary equipment, they were obliged to offer this service. Ethie Kong added that practices' uptake of ECG equipment in Brent was quite good.

Sarah Mansuralli (Brent CCG) advised that as some practices did not have sufficient space to provide certain services, arrangements were made to ensure that hubs within localities could provide these.

5. **Brent CCG: Wave 2 Commissioning**

With the agreement of the Chair, Irwin Van Colle (Chair, Kingsbury Patient Participation Group) addressed the committee. Irwin Van Colle began by stating that overall the Equalities, Diversity and Engagement (EDEN) Committee was a highly successful organisation and that in Kingsbury, most of the GP practices sent delegates to the Patient Participation Group meetings. Members heard that Brent CCG were in consultation with the EDEN Committee over constitutional matters, and whilst there had been some agreement, such as in complaints, differences of opinion remained in respect of commissioning. In particular, the EDEN Committee was against any proposals for their abolition as apparently had been suggested by the CCG on 25 September 2013 and there were competing views as to how consultation should be undertaken. EDEN Committee members also felt that the CCG was sometimes simply informing them of their intentions rather than consulting fully with them. Irwin Van Colle advised that the EDEN Committee was requesting than an open, borough-wide conference involving the CCG, the council, the EDEN Committee and patient participation groups be undertaken on extending

public and patient engagement and the committee was asked to help facilitate the creation of this conference.

With the agreement of the Chair, Julia Kirk (Co-Founder, CMH Rheumatology Patient's Support Group) addressed the committee. Julia Kirk stated that she was a rheumatology patient at CMH and attended the hospital every two months. Members heard that the Support Group was dismayed that Brent CCG had not consulted anyone before issuing a decommissioning notice on 28 March 2013 to North West London Hospitals Trust (NWLHT) confirming that musculoskeletal (MSK) services including rheumatology would cease on 1 October 2013. Upon the Support Group hearing of this in August 2013, Julia Kirk stated that she had sent a letter of complaint to Brent CCG detailing the lack of consultation and indicating that they wished the CMH rheumatology clinic and other services to continue at the Trust. Brent CCG had responded by stating that a consultation was not required and as a result, she had sent a complaint to the Health Ombudsman at stage two of the complaints procedure. She was aware that at least 50 other Support Group members had submitted their complaints to Brent and Harrow CCGs respectively. Julia Kirk outlined the details of the complaints as set out in her written statement and requested that Brent CCG withdraw the decommissioning notice on 28 March 2013, stop the tendering process, request active dialogue between Brent CCG, NWLHT and patients to help design services based on patient needs and ensure that future services continue to operate at CMH and Northwick Park Hospital (NPH).

The Chair then invited Sarah Mansuralli to introduce the report. Sarah Mansuralli advised that Brent CCG's intention to commission new pathways for outpatient specialities stemmed from the Commissioning Strategy Plan for 2009-2014. CCG's key intentions included commissioning of services to improve the health and wellbeing of its patients, secure sustainable care to receive up to date, high quality, cost effective care and ensure these services were effectively commissioned within CCG's financial resource limits. However, these aims faced a number of challenges, including a growing population in Brent and the need for more planned care as the current model was not affordable to meet future demand. There was also a need to transform care at primary, community and social levels. Sarah Mansuralli drew members' attention to the next steps as set out in the report. She stated that the concerns of patients over commissioning was understood and action would be taken to reassure them. She advised that an integrated impact assessment and full consultation would be undertaken and regular feedback would be provided to the Health Partnerships Overview and Scrutiny Committee and the EDEN Committee and there would be patient representation during the procurement process. Members heard that the CCG would respond to Julia Kirk's complaint and patients and the public would be encouraged to participate in the consultation.

During discussion by members, it was commented that patients tended to prefer that the same service provider remained as continuity offered the advantages of retaining familiarity and providing assurance. It was noted that there had been a change of provider for cardiology services and concerns were expressed with regard to consultation. A member commented that the change of provider to the Royal Free Hospital for cardiology services would impact upon out patient services. She added that there were also issues in respect of CCG's interpretation of communication as evidenced by the disagreement with regard to the EDEN

Committee and its future. Another member enquired whether TUPE arrangements for staff applied where there was a change of provider. It was asked whether the driver for commissioning of services was due to changes to the model of care. A description of the current rheumatology service and its financial budget, including details of the different levels of service, was sought and what aspects of this service were subject to commissioning. In addition, an explanation of the criteria used to decide what was suitable for commissioning was requested and it was asked whether the current provider had submitted a bid.

In respect of paragraph 5.4 in the report concerning Any Qualified Provider (AQP) and competitive tendering, a member sought clarification as to whether an existing provider could be considered as first choice where the contract was working well. Where there was to be a change of provider, information on the viability of the existing service was needed. Another member commented that retaining the same service and provider was not necessarily always beneficial and she acknowledged that the current model of care could not meet future demand and there needed to be more planned care. In respect of the consultation, she sought comments on what steps would be taken to ensure that a fair representation of the different points of view were reflected in the feedback recorded.

Councillor Hirani (Lead Member for Adults and Health) addressed the committee and enquired whether continuity of service contributed to the criteria during the commissioning process. He added that changes may lead to local providers no longer being used and also service integration could be compromised by having different providers for in an out of hospital patient care. Councillor Hirani also sought clarification with regard to CCG's level of engagement with the EDEN Committee.

In response to the issues raised, Sarah Mansuralli confirmed that the awarding of cardiology services to the Royal Free Hospital had been subject to full procurement procedures and patient representatives had been on the Procurement Panel overseeing this. The outcome of the procurement had identified the Royal Free Hospital as being capable of providing the best service overall. Sarah Mansuralli stated that a report on consultation concerning cardiology services had been to a previous meeting of the Health Partnerships Overview and Scrutiny Committee. Consultation on the second wave of commissioning was yet to formally proceed, however Brent CCG was committed to consult thoroughly and to undertake an impact assessment. An independent provider would be appointed to organise the consultation. It was noted that there had also been some initial engagement with stakeholders and more details of the consultation were to follow.

Sarah Mansuralli advised that rheumatology services was an acute service operated collectively by the North West London Hospitals Trust, the Imperial Hospital and the Royal Free Hospital, with the location of where patients were treated determined by GP referral. Members noted that both out and in patient care was provided, although spend details were currently unavailable. Sarah Mansuralli informed the committee that commissioning of rheumatology services was only taking place in respect of the out patients service and would involve consultation with both providers and patients. She added that commissioning was being undertaken because of the changes to the model of care required due to the rise in demand that the current arrangements would not be able to cope with in future. Commissioning would also ensure that the quality of care provided was sufficient

and it was intended to create an integrated service for MSK services with trauma and orthopaedics, rheumatology and gynaecology services in order to improve quality of care and outcomes, reduce duplication and streamline services. There was evidence nationally that integrating such services improved outcomes for MSK and examples in Thurrock and Basildon were cited. Sarah Mansuralli advised that the awarding of an organisation to undertake the integrated impact assessment would be completed by the end of October 2013.

Jo Ohlson advised that consideration would be given as to what services would be appropriate to be provided in out of hospitals settings and what should remain in hospitals. Members heard that cardiology services would remain in hospitals and quite possibly the more complicated of rheumatology services too. There would also be discussion of ensuring smooth transitions where there were changes to the way services were operated. Jo Ohlson informed the committee that there had been discussions with the North West London NHS Hospitals Trust in continuing to provide rheumatology services, however ultimately an agreement could not be reached. In respect of the procurement process, she emphasised the importance in treating all potential providers equally and if undue importance was attached to continuity this would unfairly favour the current provider. The selection criteria would also be discussed with patients groups and the way in which potential providers interacted with partners when surgery was required and what level of choice they offered would also be assessed. Jo Ohlson stressed that NPH would remain a fully functional hospital whilst the future role of CMH would be subject to the shaping a healthier future programme. Jo Ohlson advised that there was a full commitment to engage with the EDEN Committee and the objective was to increase engagement with patients and the public. Retention of a Brent-wide group was desired and it was important that this group was representative. Jo Ohlson advised that this did not necessarily mean that the EDEN Committee would not continue and future arrangements were still being discussed.

David Cheesman (Director of Strategy, North West London NHS Hospitals Trust) advised that North West London NHS Hospitals Trust had lost out in the commissioning process to provide cardiology services by one point and he questioned why this provided sufficient basis for the service to be transferred to a different provider.

Mark Creelman (Brent Customer Account Director) added that where services were under review, this tended to facilitate moves towards a procurement exercise and by doing so this would stimulate competition through competitive dialogue.

The Chair requested that an update be provided to the committee at a future meeting concerning rheumatology services, including budget details that would incorporate budget information on the different levels of service. She also requested more information in respect of best practice and that representatives responsible for ensuring this be invited to a future meeting to respond to members' questions. Furthermore, the Chair asked that details of risk assessments that had been undertaken or would happen be provided and information on the viability of existing services where there was a change of provider. The Chair also requested information on the costs of commissioning and de-commissioning of services in respect of cardiology.

6. **Pathology Service Serious Incident: Update Report**

Ian Winstanley (Assistant Chief Operating Officer, Brent Clinical Commissioning Group) introduced the report that provided an update with regard to the investigation into the serious incident involving the pathology service. This report focused on the aspect of the investigation concerning the pathology courier service, which although not directly associated with problems described in the root cause analysis, it had appeared that transportation and delivery times played a role in the variation of potassium levels. This is because they added to the instability of the samples due to fluctuation in temperature during storage at the GP practice or, and possibly in addition, during transportation in the laboratory both in summer and winter. Ian Winstanley advised that the task and finish group analysing this issue had concluded that the courier company should create best practice for storage of sample guidelines for GP practices. In addition, the courier company was requested to pilot a hub and spoke process where bikes collect from practices and travel a significantly shorter distance to a hub where samples would be transferred to a temperature controlled van to take the samples to the laboratory. It was intended that these measures be in place by the third week of October 2013 and initial findings would be reported to the CCG and a future meeting of the Health Partnerships Overview and Scrutiny Committee.

During members' discussion, confirmation on whether the pathology service provider was accredited yet. It was also enquired whether it was feasible for the bikes themselves to have temperature controlled storage.

In reply, Ian Winstanley advised that Clinical Pathology Accreditation (CPA) had changed the criteria for accreditation. However, the service provider had remained in constant contract with the CPA and had applied for accreditation under the new criteria and this was awaited. Jon Stewart advised that both NPH and CMH dealt with samples in the same way as any other hospital. He advised that as far as he was aware, there were no pathology courier services that transported samples using bikes with temperature controlled storage because of the difficulties in overcoming the impracticalities involved. Ian Winstanley added that it was not yet known precisely how changes to temperature affected results and GP practice storage arrangements were also being looked at.

7. **Central Middlesex Hospital Urgent Care Centre Serious Incident: Update Report**

Members noted the update report on the Central Middlesex Hospital Urgent Care Centre serious incident.

8. **Health Partnerships Overview and Scrutiny work programme 2013-14**

Members had before them the work programme 2013-14 for their consideration. The Chair sought clarification as to whether an update on the wave two commissioning could be provided at the next meeting and what lessons had been learnt in respect of consultation since wave one. In reply, Sarah Mansuralli advised that the service specification would not be ready for consultation until April 2014, however details of the planned consultation and an update could be provided before then. She stated that a number of lessons had been learnt following the wave one consultation and there would be stronger focus on patient and public

engagement. The timescale of the consultation would also be sufficient in length in order to gather all the necessary information.

The Chair requested that the independent provider appointed to organise the consultation be invited to the next meeting of the committee to provide details of their consultation programme and to respond to members' questions. The Chair also requested a paper on how hospitals and GP practices were planning to cope with the problems associated with winter, including the additional demand on services and how many GP practices were using Accident and Emergency and Urgent Care Centre units. In respect of shaping a healthier future, the Chair requested an update on progress particularly in relation to CMH. The Chair also requested that the current diabetes services and future commissioning item include details of all the services, including community services, provided and what finances were available for each of these and how did this service compare with London boroughs with similar profiles. In addition, the Chair asked that a community provider be invited to attend the meeting.

The Chair stated that maternity services in Brent was to be added to the work programme. Councillor Hunter advised that mental health, abortion services and teenage pregnancy were all items of future discussion for the committee.

9. **Date of next meeting**

It was noted that the next meeting of the Health Partnerships Overview and Scrutiny Committee was scheduled to take place on Wednesday, 4 December 2013 at 7.00 pm.

10. **Any other urgent business**

None.

The meeting closed at 9.10 pm

M DALY
Chair

Brent	**Health Partnerships Overview and Scrutiny Committee** 4th December 2013 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Health Services: Winter Provisions

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny committee may remember that last winter (2012/13) North West London Hospitals Trust's Accident and Emergency Departments struggled to cope with the additional pressures traditionally felt during the winter months. Brent CCG and NWLHT have therefore both been asked to provide the committee with details of their plans to cope with the forthcoming winter pressures.

1.2 The reports from Brent CCG and NWLHT outlines the demand faced during last winter and the analysis that has been done to look at expected demand for the forthcoming winter. It outlines discussions with the NHS Trust Development Agency, NHS England and key actions that have been or will be put in place to address the traditional winter pressures, with a focus on alleviating A&E bed spaces.

1.3 The proposals include a number of measures, notably to increase bed capacity (both internally and through external sites) and a reduction in the number of DTOCs (Delayed Transfer of Care). The CCG report provides an assessment of the net estimated gap in bed capacity taking account of the projected additional beds.

2.0 Recommendations

2.1 The committee is recommended to consider the measures proposed in the report and question officers further in order to establish whether it agrees these measures are appropriate and sufficient to address the strain on the system that is anticipated in the approaching winter months.

Contact Officers

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The North West London Hospitals NHS Trust

BEHH Brent Ealing Harrow Hillingdon Clinical Commissioning Groups

Winter Planning Update

Health Overview & Scrutiny Committee

18 November 2013

Jo Ohlson, Chief Operating Officer, Brent CCG
Tina Benson, Director of Operations, NWLHT

Background

The Health Overview and Scrutiny Committee are reminded of recent events that impact on the winter planning process and are included in winter surge planning:

- Winter bids to NHS England (NHSE) for additional funding 2013/14
- Further plans to reduce A&E attendances and admissions
- Capacity planning undertaken by Capita
- Responses received
- Key risks
- Further actions being considered
- Matters for Governing Body

Winter bids

The following schemes were awarded funding across the local Brent-Harrow health economy

WINTER SURGE SCHEME	RESPONSIBLE ORGANISATION	VALUE
Top slice – NHSE advised scheme	NIHR CLAHRC	£ 50,000
Top slice – NHSE advised scheme	LAS intelligent conveyancing	£ 190,000
Additional acute bed capacity – 34	NWLHT	£ 2,000,000
24/7 working to improve flow	NWLHT	£ 2,200,000
Enhance STARRS		
Weekend therapy		
Extra CEPOD lists		
24 hr surgical assessment unit		
Medical 7 day ward rounds		
24hr stroke service		
Extended hours of Gynae assessment unit		
24 hr critical care outreach		
Extra diagnostic and anaesthetic support		
DTOCs	Brent/Harrow CCG	CCGs to fund
20 additional beds in Willesden	Brent Community	£ 1,065,000
Acute Psychiatric unit – co-located	CNWL	£ 459,000
Residential Reablement beds x 6	Brent Adult Social Care	£ 88,000
Residential Reablement beds x 6	Harrow Adult Social Care	£ 88,000
Denham	Harrow Community	£ 312,000
	Total	**£ 6,452,00**

Further plans to reduce A&E attendances & admissions

In addition to winter bid plans, Brent CCG has implemented the following schemes

SCHEME	ACTION	IMPACT
NWPH North Brent LAS divert – Full year contract - £400,000	Divert takes place between 8am – 7pm	Equivalent to an estimated 8 beds / year at NWLHT or 4 avoided attendances per day
Brent CSPA –Clinical single point of contact pilot for 6 months at NWPH - £500,000	Provides senior GP advice on alternatives to admission to A&E and to Brent & Harrow GPs on alternatives to A&E admissions; supports planned effective discharges	Only GP advice in A and E to date with limited impact on saved admissions (target 1 a day) 2 remaining elements to go live on 4 November
Launch Brent & Harrow ambulatory care pathways to increase flow through A&E by GP direct referrals	10 agreed ambulatory care pathways rolled out 31st July 2013. Expansion to 20 pathways to be progressed.	Not in as position to report on impact will have data from CSU from month 6 (August)
Harrow STARRS	NWLHT working to revised spec to act on pre 4 hour activity only Annual target of 1000 A&E and 1700 NEL avoidance	A&E demand management FOT – 909 NEL demand management FOT - 1494
Harrow STARRS stretch 14/15 (13/14 Nov –March ramp up opportunity). Awaiting CCG sign off to implement in year	(13/14 Nov –March ramp up opportunity). Awaiting CCG sign off to implement in year	A&E demand management target – 193 NEL demand management target – 349
Brent STARRS £4m	GP and A&E referrals	2230 avoided admissions per annum - achieving
Brent STARRS Stretch £68,000	Extension of STARRS from 20.00 to 22.00	Additional 12 avoided admissions per day
Increasing GP access in (6 month pilot) - £900,000	5 locality hubs open 3pm to 9pm Monday to Friday and, 9am to 9pm Saturday – (37,000 additional appointments)	Harness & Kilburn start in September Wembley & Kingsbury start in November
Brent Willesden 7 day therapy - £800,000	Provision of therapies Saturday & Sunday	Increased bed throughput and reduced length of stay (achieving)
Direct ambulances to UCC at Northwick Park & Central Middlesex sites	Exclusion criteria at Northwick Park site and inclusive criteria at Central Middlesex site	4 avoided attendances per day across both sites
Integrated Care Pilot Brent & Harrow	Multidisciplinary teams (threshold funded)	Harrow £12,000 to date Brent £ nil to date

Capacity planning by Capita

Capita provided demand and capacity calculations for the Northwick Park site are as follows:

	OCT	NOV	DEC	JAN	FEB	MAR
ESTIMATED TOTAL DEMAND FOR ACUTE/GENERAL BEDS (CAPITA)	**253**	**251**	**276**	**293**	**285**	**271**
ACUTE MEDICAL BEDS ON THE NORTHWICK PARK SITE	195	195	195	195	195	195
WINTER BIDS:						
Additional acute beds (winter ward)			20	20	20	20
Community beds (Willesden)	0	0	20	20	20	20
Reablement beds (Brent+Harrow)	12	12	12	12	12	12
Increased capacity at Denham Unit	3	0	3	4	7	10
ESTIMATED CURRENT GAP IN CAPACITY	**43**	**44**	**26**	**42**	**31**	**14**
PLANS UNDER DEVELOPMENT						
Additional beds at Willesden			12	12	12	12
Clayponds		5	5	5	5	5
Mount Vernon additional beds			20	20	20	20
Repatriation of patients to Ealing		3	7	7	7	7
Additional reablement beds (Brent)			6	6	6	6
Spot purchase of beds for DTOCs	20	20	20	20	20	20
ESTIMATED FINAL GAP IN BED CAPACITY	**23**	**16**	**-44**	**-28**	**-39**	**-56**

Figures in red represent a shortage of beds

Plans to reduce Delayed Transfers of Care (DTOCs) from hospital to community setting

Root Causes

- Awaiting health and / or social care assessments
- Awaiting residential / nursing home placements (health and / or social care)
- Lack of appropriate / accurate information on potential discharges

Actions Agreed

- Additional social worker and continuing healthcare assessor capacity within NWLHT discharge team
- Additional six reablement beds leading to a total of twelve beds
- Three additional NWLHT discharge assistants (winter only) within NWLHT discharge team

Responses received

Health Overview & Scrutiny Committee will wish to note the responses received following recent discussions with Tripartite Panel and NHS England assurance meetings:

Tripartite Panel: NHS Trust Development Agency (NHSTDA), NHS England (NHSE), North West London Hospitals Trust (NWLHT) and Brent Clinical Commissioning Group (BCCG)

- Confirm bed gap for a sustainable level of acute bed demand
- Plan efficient use of bed capacity across whole of NWL including Ealing
- Submit a trajectory for achievement of 95% A&E target
- Take part in whole system review of how best to utilise bed capacity in London

NHS England

- NHSE noted the extent and scope of the CCGs plans – as summarised above
- NHSE noted the focus on reducing number of DTOCs
- NHSE will follow up on loss of benefit rules that were delaying discharge
- NHSE acknowledged that the Trust and CCG were working more effectively together

Capacity

- NWLHT is using the capacity at both NPH and CMH to ensure all available beds are used for suitable patients
- CMH additional flow from medical treat and transfer; rehabilitation patients and repatriation from other Trusts
- Nurse co-ordinator employed to manage flow between sites
- Patients' information given on admission
- Additional elective work occurring at CMH to support delivery of 18 week target
- Further elective work needs to occur at CMH and reconfiguration of services will be required to achieve this including increasing capacity for Emergency work at NPH

Information to Patients and Consultation

- On admission to NWLHT, patients are informed they may complete their care in another setting when they are medically fit for discharge, but need further healthcare (Willesden, nursing home, Mount Vernon Hospital)

- Brent patients currently attend hospitals outside Brent: Ealing, Imperial College Hospital Trust, and the Royal Free. Brent CCG is in discussion with NHSE and NHSTDA about the flows to these hospitals increasing if NWLHT cannot cope with demand during the height of the winter pressures

- Brent CCG and NWLHT will keep the Health Overview & Scrutiny Committee informed of any emergency measures that might need to be taken and to agree public consultations required if planned changes were significant

Matters for Health Overview & Scrutiny Committee

The Health Overview & Scrutiny Committee are asked to note the current situation and risks; and, support the following actions:

- Support efforts to reduce number of delayed transfers of care (DTOCs) by local authorities
- Monitor DTOCs for social care and housing services
- Monitor implementation of winter monies and relevant QIPP schemes
- Promote all schemes that reduce A&E attendances and admissions with GPs
- Movement of backlog of elective operations to other providers
- Support for GPs referring patients for elective procedures to other providers to free up capacity on Northwick Park site
- In the forthcoming contracting round, improve balance of the demand for elective and non elective acute care across all providers
- Monitor progress of winter surge planning

In addition Health Overview & Scrutiny Committee may wish to propose other actions not considered above

Key risks

The Health Overview & Scrutiny Committee will wish note the following risks for the local health economy:

- Recent progress on Mount Vernon beds has addressed short-fall in non-acute bed capacity; especially, in December and early January
- Additional community / step-down beds may not be suitable for acuity of case mix
- 18 week RTT backlog
- A&E 95% target performance
- Demand and capacity remain a systemic problematic at Northwick Park site

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Winter Preparedness and A&E performance

1. Purpose

The purpose of this paper is to describe to the actions taken since last winter and describe the position going into winter 2013.

2. Background.

The risk the trust carried through last winter in terms of patients waiting excessive times in the emergency department was too high. Whilst patient safety is the key priority, evidence shows that an overcrowded emergency department can increase patient mortality over the longer term. This is the evidence which supports the importance of delivery of the DH four-hour emergency target.

Since February 2013 the trust have taken a number of actions to:

a) increase physical bed capacity

b) improve flow through the emergency pathway

c) embed seven-day working

In addition, in June 2013 the board agreed to proceed at financial risk to put in place further capacity and actions to address on-going demand and capacity issues. These were agreed to further reduce the risk to delays to treatment and/or admission to the patients on the emergency pathway from that the trust carried in the winter of 2012.

3. Emergency department and acute medicine.

The following have been achieved since Feb 2013:

- Increased nursing staff and middle grade doctors
- Improved equipment and monitoring facilities as well as a refurbished Zone 2
- STARRs are present in the ED but their hours have now been extended. In addition a STARRS lounge is in place (funded by CCG) by a further 2 hours in to the evening
- GP in ED (CCG funded)
- There is a slightly expanded acute assessment unit and includes additional high dependency beds (6 additional trollies and 2 HDU beds).
- We are changing to a two consultant medical take as we have additional physicians during the day.
- Significant increases in ambulatory care management (CCG pump primed)
- Site practitioners supporting acute medicine out of hours enhancing hospital at night

4. Acute surgery and critical care.

The following is either already in place or in progress to be in place during November 2013:

- Urology team of the week in place
- Expanded surgical assessment unit as well as increased hours (hours increasing to 24/7)
- Extended opening hours of the Gynaecology Direct Referral Unit this means and additional 2 hours per weekday and 8 hours per day at the weekends.
- ENT Doctor cover in place overnight
- Additional 5 consultant emergency surgeons for 24/7 critical care outreach
- Additional evening CEPOD lists in place
- Additional anaesthetic consultant posts (7wte) out to advert

5. Improved flow and out of hospital.

Improved flow:

- Additional weekend radiology
- Additional seven day working in therapy services
- LAS North Brent Divert which means all patients picked up from a location in Brent go to CMH where clinically appropriate.
- Sickle cell passport so that these patients can be conveyed to CMH which is their normal place of care even when A&E is closed.
- CSPA navigation to non-Brent and Harrow patients to ensure community providers are contacted and delays for these patients are minimised.

Out-of-hospital:

- Redirection from UCC so patients use emergency facilities more appropriately and are given an urgent appointment at their GP.
- Primary care hubs (Brent) to provide as a minimum 12 hour per day access to primary care clinicians.
- Nursing home attendance avoidance Harrow to prevent patients having unnecessary hospital attendance and more robust planning to allow them to be maintained in the nursing home which is less distressing for patients.
- Integrated End of Life Harrow to have mulit-agency care plans to prevent admissions to die where this is not in the wishes of the patient.
- Frequent Flyers work (Trust, LAS and both CCG's) to put in place care plans for those frequently attending A&E or getting admitted to the Trust.

6. Bed capacity.

The table on the following page shows an outline of the change in capacity from last year to this year including both the acute and community capacity. Board members will recall that the Capita capacity modelling undertaken in the summer identified that the Trust had a shortfall in bed capacity of 89 beds as illustrated below.

Bed capacity 2012/13 compared with 2013/14

Acute Trust	2013-14						2012-13											
	Planned core bed capacity @ 31 Oct 2013			Planned additional contingency capacity for winter period (Nov 2013 - Feb 2014)			Bed capacity @ 31st Oct 2012			Additional contingency capacity for winter period (Nov 2012 - Feb 2013)			Current capacity compared to last year (e.g. col A minus col D etc.)			Planned additional contingency capacity - this winter compared to last year (e.g. col D minus col J etc.)		
	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU	General and acute	ICU	PICU
	A	B	C	D	E	F	G	H	I	J	K	L						
NWLH	699	19	0	28	0	0	629	19	0	58	0	0	70	0	0	-30	0	0

Commentary

All 58 escalation beds from last year are now part of the core capacity in the Trust.

Additional Non-Acute Bed Capacity Commissioned (Trust or non-Trust) to address identified winter capacity gap for 2013

51beds are in the process of being put in place (identified) for this winter against the spot purchased capacity of 36 for last year. There will also be an additional contingent capacity to l be spot purchased if case mix demands further capacity (up to 22 extra beds).

Final Commentary

Even with the additional 70 substantive beds from last year's escalation remaining open the Capita demand and capacity model identified a further capacity gap of up to 89 beds As a result of the action above for the 51 beds, the Health economy will have closed the gap to a potential 38 beds shortfall at the winter peak assuming no reduction in LOS or QIPP delivery. There is however the potential for further external capacity of 22 beds.

7. Performance in September 2013.

During September performance was challenging for the organisation and showed a marked deterioration from performance in June, July and August. The reasons for this were multifactorial, including:

- Lack of bed capacity. Bed breaches have moved from 92 in Aug to 342 in September. 31% of all breaches were caused by lack of availability of a bed.
- DTOC's are rising (485 bed days in Aug to 772 in Sep). The reduction to 100 bed days (DTOC's) committed to by Commissioners in the recently submitted recovery trajectory plan to the TDA and NHS England have not been delivered. Patients not formally assessed as delayed but in reality are awaiting discharge add a further 400 bed days in September, double the previous months.
- Year-to-date, approximately 2000 patients are still attending ED when the HRG suggests they could be seen in the UCC at NPH and about 150 at CMH.
- Specialty breaches remained at approximately 16%.
- ED breaches were increased at 17%.

Improvement of breaches within the direct control of the hospital will be achieved by:

- Increasing the availability of surgical assessment unit and the Gynaecology direct referral unit. as described above for increased hours over the week.
- Increased senior management of the ED seven days a week.

8. Conclusion.

The trust has currently submitted a recovery trajectory which gives the year-end performance of 94.4% against a target of 95%. This assumes a number of actions outside of the control of the organisation are delivered including demand management schemes and reducing delayed transfers of care to 100 days per month. However, given performance on these to date there is a continuing risk in delivering the submitted trajectory.

Despite submitting a trajectory which shows non-delivery of key national target, the action taken by the organisation to date will assist the Trust in reducing the risk for patients and reducing pressure on staff. , Despite this the organisation will come under significant pressure to deliver the 95% target. Ultimately the key to unlocking delivery of this reliably and consistently is to increase the physical bed capacity on the NWP site for which a business case could be delivered for next winter however, all physical space on the Northwick Park site has been maximised for the current year. That said the Trust will continue to do all it can to achieve the 95% target and put in place all the actions described above that are under its direct control.

Tina Benson
Director of Operations
October 2013.

The North West London Hospitals NHS Trust

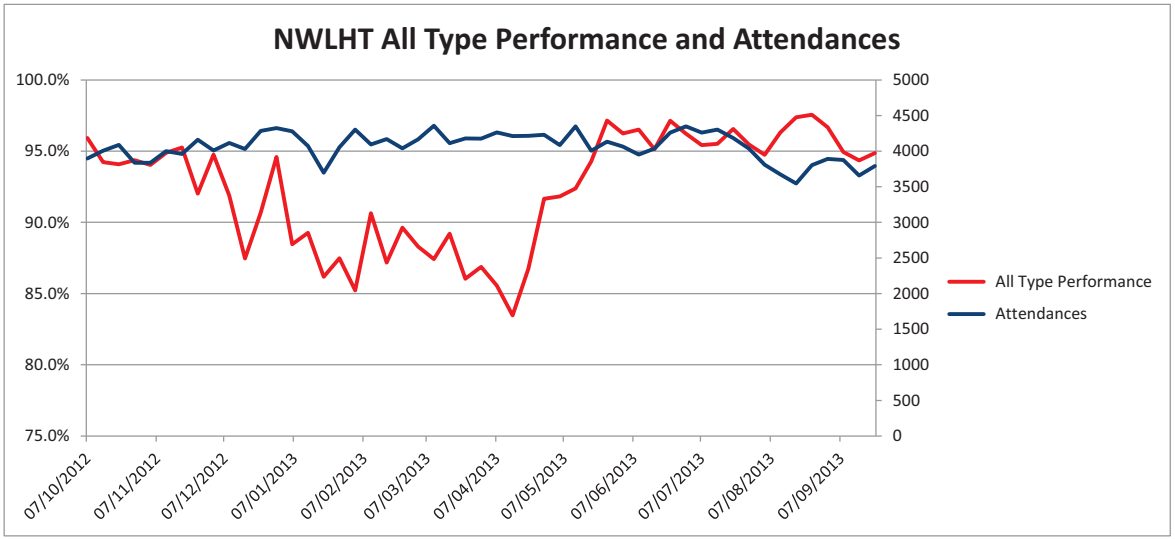
A&E Performance

Drivers, challenges and potential solutions

The North West London Hospitals NHS
NHS Trust

Current performance

The graphs below illustrate A&E performance and activity over the last 4 quarters:



	Quarterly Performance			
	Quarter 3 12/13	Quarter 4 12/13	Quarter 1 13/14	Quarter 2 13/14
North West London Hospitals	93.37%	87.83%	92.60%	95.81%

The Trust had a very challenging winter last year and the pressures were felt until the end of May where performance started to pick up at above 95% All Type. Performance remained above 95% until the beginning of September, with the exception of one week (4th August).

Pressures are now being felt again and the implementation of winter schemes, together with robust demand and capacity modelling should have a positive impact on keeping Q3 performance above 95% until December. Slide ten outlines the performance trajectory going forward.

Drivers and root causes of variance

	Reason for breach	Action taken to date address this reason	Impact on performance
1	Lack of Bed Capacity	• Capita modelling complete • Regular internal reporting/audits on bed state • All extra physical capacity open • Maximum use of beds at CMH e.g. diverting GP take there • Purchasing of 20 Nursing Home beds for DTOCs • Open and use of Ambulatory care • Improved timings of discharges • Daily board rounds and working towards 7 day ward rounds • Potential plan to open 8 beds in November and 26 beds in December • Escalation to CEO in place • STARRS in A&E • DTOCs discussed at at 9.00 am teleconferences • Increasing community provision and better flow • Number of winter schemes which reduce DTOCs and LOS	Reduction of bed breaches compared to June, July and August
2	Emergency Department/Assessment	• 2 hourly board rounds with consultant during the day • Review of Pit-stop process • Recruitment of Consultants and Middle Grades • Fixed Term contracts for locum doctors • Increase Physicians Assistant role	Reduction of Emergency Department breaches compared to same period last year.
3	Clinical and Increased Acuity	• Monitor and validate all clinical breaches • Extra Medical Reg at night to assist in resus • Extra SHO at night for Stroke to pull patients from resus • 24 Critical Care Outreach in place	
4	Speciality Referrals	• Increase capacity in SAU to 24/7 - November • ENT doctors at night - November • Additional weekend Surgical Reg 09.00-21.00 Sat/Sun • 13 hour consultant lead ward rounds in surgery • Increase Gynae Assessment Unit 7 days a week	Reduction of Speciality breaches by **Surgery** - Reduction in breaches from 40 to 20 per week **Gynae** – reduction in breaches from 8 to 4 per week **ENT** – reduction in breaches from 10 to 5 per week **Mental Health –** reduction in breaches from 12 to 4 per week
5	Adult and CAMHS Mental Health	• Fortnightly Senior Management Meetings between Trust and Commissioners • Conversion of 6 inpatient beds – December • Revised escalation process • Dedicated AMHP (Approved Mental Health Professional) – December	Reduction of Mental Health breaches from 20 to 12 per week

Drivers and root causes of variance cont.
Residual Bed Gap

1. Winter monies will allow us to assume, at risk; 12 re-ablement, 14 NH beds and 20 Willesden, 28 NWLH, however the bed gap by month from October will be:

2. Further possible schemes include:

- 10 beds at Willesden
- 5 beds at Clayponds
- 7 beds Ealing (repatriation)

This is considerable better but still leaves a gap of:

Oct	Nov	Dec	Jan	Feb	Mar
-29	-22	-10	-6	+5	+22

Plan and key actions

The following are the top 5 initiatives through which we seek to improve flow:

	Issue	Action	Improved Impact
1	Inappropriate patients in observation area Elderly patients inappropriately admitted	• Enhance STARRs team to case manage these patients • Place STARRs team at front of hospital to work alongside A&E teams	10 patients discharged from observation weekly as admission avoidance
2	Delays to flow and discharge	**Monitoring of EDDs** • All wards now have electronic whiteboard where EDDs are monitored daily **Increased Timeliness of discharges** • 2 Hourly monitoring of discharge times **Increased Discharges at Weekends** • All specialities to use Discharge Bundles at weekends • Physio and OT working 7 days a week **Reduction in waits for Diagnostics** • Diagnostics to join handover meetings on Fridays **Improved Outcomes for level 2 patients** • 24 critical care outreach **Hospital at Night Team** • Re-launch of roles and responsibilities of hospital at night team **Flow of Rehab patients** • Ortho Rehab patients to CMH	95% accurate EDDs on every patient To free up beds earlier in the day to provide capacity. To move our average discharge time from 4pm to 12 midday. 10 additional discharges at the weekends Reduction of level 2 patients on AAU To free up 6 beds on the NPH site per week
3	Increased delays due to lack of theatre capacity	• Increase trauma to 3 session days on Monday, Wednesday and Friday • From November roll out to 5 days a week • CEPOD – planning additional evening/Twilight sessions on Tuesday, Wednesday and Thursday – October	Less than 2 inpatients awaiting daily for operations No medically fit #NoF waiting more then 36 hours No more than 5 outpatients on the list
4	Speciality Breaches Surgery Gynae ENT Mental Health	• Medicine – increase on take staffing • 3 consultant rota to be in place - December • 24 hour SAU • extended opening hours • Dr at night to support admissions • Assessment unit within Mental Health wards	**Surgery** - Reduction in breaches from 40 to 20 per week **Gynae** – reduction in breaches from 8 to 4 per week and No clinically appropriate patients to wait in A&E **ENT** – reduction in breaches from 10 to 5 per week **Mental Health –** reduction in breaches from 12 to 4 per week
5	Increased delayed discharges and patients on the pathway	• Earlier escalation to senior staff • Twice weekly Whole Health Economy teleconference • Purchasing of Nursing Home beds • Weekly escalation at Sub-board of Urgent Care Network Board	Reduction in less than 100 beds days in a month

Plan and key actions cont.
Other Breaches Plan

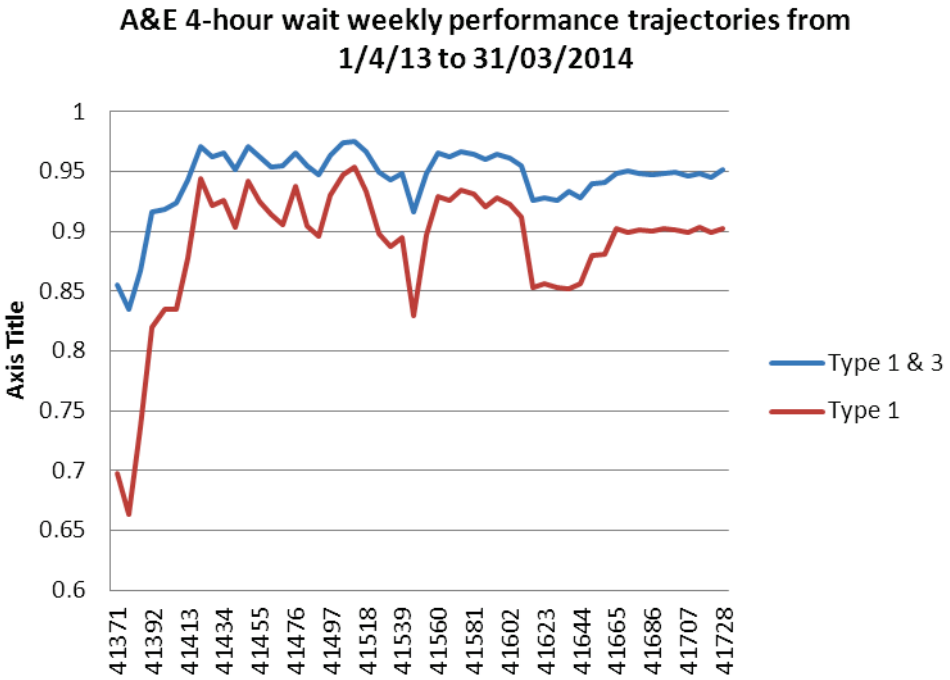
- Speciality addressed as flow in the winter plan:
  a) SAU expansion to 24/7
  b) ENT overnight doctors
  c) GDR 7 day working and extended hours

- Mental Health:
  a) Acute assessment unit in CNWL on NPH site

Plan and key actions cont.
Trust Breaches Plan

- ED breaches
  a) Low threshold (no more than 5) agreed with team
  b) New criteria for Obs ward
  c) Permanent senior manager/ clinician on floor inc. weekends.

Trajectory for recovery



At present, the Trust cannot commit to performing for the duration of Q4, and consequently the year end position.

	Type 1 & 3	Type 1
Qtr 1	92.60%	84.66%
Qtr 2	95.41%	90.89%
Qtr 3	95.05%	85.02%
Qtr 4	94.61%	89.53%
Annual	94.40%	87.73%

The North West London Hospitals NHS
NHS Trust

Brent and Harrow Recovery and Improvement Plan – updated 20th November 2013

This document was reviewed by the Brent & Harrow Urgent Care Operations Group on 20th November 2013. In light of the need to report back to NHSE on our Recovery & Improvement Plan, the plan has been mapped out against their reporting structure. Actions are included below under the relevant NHSE headings.

- **Increased numbers of patients arriving at A&E. There is a general rising tide with 5.9% more attendances in 2012/13, than in 2009/10. However, the total numbers attending in Q4 of 2012-13 (which is when the significant deterioration began) was 1.7% lower than the previous Q4.**

- **Increased number of acute admissions putting pressure on beds. There were 10.6% more emergency admissions in 2012/13 than in 2009/10. There is general consensus (though it is hard to identify the evidence) that patients presenting are more ill and hence more likely to need admission and have longer stays.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Consistent use of co-ordinate my care To reduce EOL NEL admissions.	CCGs/Brent: Gillian Gale		16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	ICP to target process for A&E frequent attenders. To avoid unscheduled care where possible directing patients away from A&E. Will we see a reduction on NEL admissions over a period of time if this list is obtained?	Tina Benson Sheik Auladin Dr Mo Ali Susan Hearn	**NWLHT to provide list of A&E frequent attenders.**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Harrow ICP Innovation fund schemes live. To avoid unscheduled care where possible directing patients away from A&E. Need KPIs to define success, what we expect the reduction to be.	Sheik Auladin, Dr Amol Kelshiker Jason Antrobus	**CCGs to define KPIs.**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Brent ICP Innovation fund schemes live. To avoid unscheduled care where possible directing patients away from A&E. Need KPIs to define success, what we expect the reduction to be.	Sheik Auladin Jason Antrobus	**CCGS to define KPIs**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	NWLT action plan to drive improvement in patient handover performance, working towards achievement within 15, 30 & 60 minutes from arrival, 100% of the time. To ensure improvements in ambulance turnaround processes/KPIs are achieved and maintained.	Peter Rhodes James Walters	**Fortnightly meetings been held with Trust and LAS**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Expansion of Ambulatory Care pathways to 20 pathways. To prevent admissions and use as point of entry to care of patients in the community.	John Swiatczak Jason Antrobus	**Meeting had with NWLHT. Plan for trust to issue set of draft pathways for clinical review on 26 November**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	NWLHT and CCG sign off of counting, coding and costing. To ensure accurate recording and funding of A&E and Ambulatory Care activity.	Tina Benson, Stephen Dixon Liz McLean	**Data flag – difficult to obtain.**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Performance management of current commissioned service and admission avoidance targets. Delivery of admission avoidance QIPP plan for 2013/14.	Jason Antrobus,	**Systems in place.**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Start Harrow STARRS procurement process (advert out on Suppl2Health). Re-procurement process to acquire a single provider to deliver the revised specification.	Jason Antrobus	**Following collaboration route now, not procurement. Letter drafted, reviewing internally with CCG before issuing next steps to NWLHT**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Finish Harrow STARRS procurement – contract signed for new service provider. Delivery of admission avoidance QIPP plan for 2014/15 and bridge 2013/14 shortfall.	Jason Antrobus, Dr Dilip Patel	**Following collaboration route now, not procurement. Letter drafted, reviewing internally with CCG before issuing next steps to NWLHT**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Direct to speciality pathways (i.e. not through A&E) for UCC, STARRS and NEL patients including surgical assessment unit and ambulatory care. To avoid unscheduled care where possible directing patients away from A&E.	Tina Benson, Jo Ohlson, Javina Sehgal, Dr Kanesh Rajani, Dr Sami Ansari	**Completed.**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Identify CQUINS for unscheduled care admission avoidance (NWLHT). To avoid unscheduled care where possible directing patients away from A&E and NEL admission To deliver high quality unscheduled care where necessary.	Jo Ohlson, Javina Sehgal, Jane Rooney, Tina Benson Bernard Quinn Stephen Dixon		16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	On-going achievement of defined CQUINS (Ealing ICO). To increase community support and response times To deliver high quality unscheduled care where necessary.	Sharon Gregory, Elizabeth Youard, Rebecca Wellburn, Jason Antrobus, Dr Genevieve Small, Dr Kaushik Karia	**Awaiting response from ICO. Local CQUINS drafted, following up with contracts team**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Co-ordinate my care training for all practices. To reduce EOL NEL admissions	Jason Antrobus, Gillian Gale	**Completed. Practices to access as required**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	NWLHT to identify A&E frequent attenders and circulate to ICP. To avoid unscheduled care where possible directing patients away from A&E	Tina Benson, Sheik Auladin	**FF data shared to ICP team**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	ICP programme live across Brent and Harrow. To avoid unscheduled care where possible directing patients away from A&E	Sheik Auladin	**Completed**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Case Manage more patients through Adult Community Nursing. Avoid hospital admission where appropriate	James Walters, Ealing ICO	**Completed**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	LAS to UCC pathway (NPH and CMH). To avoid unscheduled care where possible directing patients away from A&E	Peter McKenna	**Completed**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	LAS to reinforce use of UCC/STARRS with Crews. To avoid unscheduled care where possible directing patients away from A&E	Peter McKenna, Pauline Cranmer	**On-going reinforcement and reviewing of joint protocols**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	CCGs and NWLHT to review LAS data and identify on-going actions. To avoid unscheduled care where possible directing patients away from A&E	Tina Benson, Jo Ohlson, Javina Sehgal	**Completed**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Breach analysis: Understand causative factors: 1. Robust process in place to identify on-going issues and gaps within process. To ensure improvements in ambulance turnaround processes/KPIs are achieved and maintained	HB, John Swiatczak	**Completed**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Ambulance turnaround meeting:1. Re-establish regular (fortnightly) meetings with key stakeholders: Head of Site Practitioners, HoN, ED Service Manager, LAS Operational Commander, General Manager for Emergency Medicine, Governance Lead, ED Consultant. To ensure improvements in ambulance turnaround processes/KPIs are achieved and maintained	John Swiatczak	**Completed**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Informal launch of Ambulatory Care Unit and 5 clinical pathways. To avoid unscheduled care where possible directing patients away from A&E	John Swiatczak	**Implemented**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Joint operational protocol for UCC to STARRS at NPH. To avoid unscheduled care where possible directing patients away from A&E attendance	Claire Walker, Dan Annetts	**Protocol and joint working in place. Final sign off of protocol at unscheduled care group required**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Contract notice served on current admission avoidance (STARRS Harrow) provider. Re-procurement process to acquire a single provider to deliver the revised specification	Kathryn Magson, Dr Dilip Patel	**Completed**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Implement Clinical Single Point of Access "GP in ED". To avoid unscheduled care where possible directing patients away from NEL admission. We anticipate that we will save one unplanned admission to hospital per day	Jo Ohlson, Gillian Gale, Dr Ethie Kong	**GPs recruited – developing rota, go live 1 July 2013**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Increase step-up beds utilisation within Willesden Community beds base. To avoid unscheduled admissions through diversion to community bed base where appropriate and safe	James Walters, Ealing ICO	**Complete, utilisation now increasing. Looking at taking capacity from NPH if >5 beds vacant, to be agreed by 05/07**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Senior Physician and COE Physician in ED – appropriate clinical skill mix (subject to availability). To avoid unscheduled care where possible directing patients away from NEL admission	Tina Benson	**Prioritising sessions Using locums mainly during OOH and Weekends when available**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	2012/13 CQUIN schemes to be established as business as usual within NWLHT core services. To deliver high quality unscheduled care where necessary	Jane Rooney	**Implemented and now monitored through PCE and CQG**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Hospital Arrivals System compliance 90% of the time. To ensure improvements in ambulance turnaround processes/KPIs are achieved and maintained	Peter Rhodes John Swiatczak	**Can only measure ED attendances not UCC**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Escalation undertaken in a timely and consistent manner. To ensure improvements in ambulance turnaround processes/KPIs are achieved and maintained	JS/JOD/HB/NW/RC	**Underway - In-hours completed, out of hours complete by end of July 2013**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Formal launch Ambulatory Care - CCG formal communication of launch to GP practices. To avoid unscheduled care where possible directing patients away from A&E	Jo Ohlson, Jason Antrobus, John Swiatczak, Dr Sami Ansari, Dr Kanesh Rajani	**Clinical sign off achieved, awaiting resolution of the counting, coding and costing. Revised due date 31 July**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Admission avoidance services commissioned across Brent and Harrow CCG. To avoid unscheduled care where possible	Ian Winstanley, Jason Antrobus, Dr Dilip Patel, Dr Sarah Basham	**On-going**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Establishment of STARRS consultant (Harrow) across commissioned hours of service. Delivery of admission avoidance QIPP plan for 2013/14	Claire Walker	**Outcomes delivered**	16/10/2013	2/12/2013

- **Hospitals being less proactive in process management which plays a very significant part in their ability to admit patients. Patients who require admission are the ones who are most likely to wait over 4 hours.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Implementation of risk stratification tool to assess flow of admissions. Effectively review admission flow and provide information for future commissioning decisions.	Liz McLean Stephen Dixon		16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and OOH Care)	Consultant led speciality ward/board rounds starting with general medical consultant in time for the weekends. Increased capacity to support flow and discharges.	Tina Benson	**To ensure complete by 2/12/2013.**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and OOH Care)	Joint dispute resolution policy agreed between Harrow CCG and Harrow Council. Increased capacity to support flow and discharges.	Javina Sehgal, Paul Najsarek, Dr Amol Kelshiker, Rob Larkman		16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
3. Improved discharge performance (Stage C: Discharge and OOH Care)	Brent and Harrow CCGs to develop a process for 48hr spot purchasing (starting with those with a health need waiting more than 48hrs post formal DTOC). Increased capacity to support flow and discharges.	Jason Antrobus, Sarah Mansuralli, Dr Amol Kelshiker, Dr Ethie Kong	**Harrow & Brent sent a revised paper to the Board; the model has been signed off and is in use. There are complex patients in the pathways that are difficult to apply the model to.**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	New Acute Imaging team separate from elective work. Consultant led service with Acute PAs. Deliver improved turnaround times for reports across CT/US and plain film across the emergency pathway. Improve patient flow and avoid congestion and delays in A&E	Sean McCloy	**On target**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	NWLHT to open an additional 21 escalation beds between 4 May and 30 September 2013. (This is in addition to the existing 40 escalation beds currently operational). Extra capacity to improve patient flow and avoid congestion and delays in A&E	Tina Benson, Rory Shaw	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	NWLHT to open additional capacity on both sites to support the emergency pathway in line with NWLHT internal capacity plan (with CCG sign off). Extra capacity to improve patient flow and avoid congestion and delays in A&E	Tina Benson, Maeve O'Callaghan-Harrington	**Same action as Row 61 so marking as Complete to remove from tracking (MLB)**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Direct to Specialty pathways for UCC/ED Surgical Assessment Unit. Cohort of admissions to minimise handovers Avoid congestion and delays in A&E	Maeve O'Callaghan-Harrington All Surgical Clinical Directors	**Nursing staff recruited. Extended the space Complete Increase by 4-5 patients per day in first week**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Rapid assessment of patients referred to specialty. Avoid congestion and delays in A&E	Maeve O'Callaghan-Harrington	**Same as above action**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Direct to Ambulatory Care pathway for UCC/STARRS/GP referrals (avoiding A&E attendance). Avoid congestion and delays in A&E	John Swiatczak, Dan Annetts, Claire Walker		16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Performance management of EEDs in high priority wards (Acute medicine) with effect from 1 May 2013 and to share process with CCGs. Increased capacity to support flow and discharges	Tina Benson, Claire Walker	**Process in place 92% compliance on weekly audit completed Weekly audits First report Wednesday 15th May**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	EDDs set at the point of admission for all patients (any ward). Increased capacity to support flow and discharges	Tina Benson, Claire Walker	**Marked as complete as same action as row above**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	4 new consultant posts recruited to and a senior grade rota in place 24 hours a day 7 days a week. Increased capacity	John Swiatczak, Sean Williams	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Additional ENP's (Emergency Nurse Practitioner). Increased capacity	Julie O'Donoghue	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Increase in the consultant cover of the Medical Take. Early senior review and expedite decision making and twice daily ward rounds (RCP guidelines 2012)	Tina Benson, Rory Shaw	**Regular meetings in place. Rotas been redefined. May be July before completed**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Senior Consultant support to Urology patients. To enhance patient flow and ensure patient is seen at night time by right person in right place.	Tina Benson	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Senior Physician and COE Physician in ED. To enhance senior decision making in Emergency Department	Tina Benson	**Same as earlier action**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Introduction of RAT'S (Rapid Assessment and Treatment) to enhance service decision making. Improve patient flow and avoid congestion and delays in A&E	John Swiatczak, Sean Williams	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	New clinical protocols launched with speciality teams for specific conditions. Improve patient flow and avoid congestion and delays in A&E	Sean Williams	**Completed**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Ownership of speciality issues across all medical, surgical teams. Improve patient flow and avoid congestion and delays in A&E	Rory Shaw	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Multidisciplinary Governance structure with Emergency Department. Improve patient flow and avoid congestion and delays in A&E	Sharon Morgan	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Electronic Whiteboar. Improve patient flow and avoid congestion and delays in A&E	Tina Benson	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	STARRs in UCC and Observation Wards. To avoid hospital admission where required	Claire Walker		16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	ENT and Max Fax. Cohort of admissions to minimise handovers	Jayne Adams, Manoli Heliotis	**Plan in place for new pathway, not yet delivered. Due 2nd week of August**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Establishment of a Chest Pain Unit	Nigel Stephens	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Well established surgical assessment unit	Tina Benson	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Twice daily consultant ward rounds on Acute Assessment Unit 7 days a week	Keith Steer	**Completed**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Well established ward escalation plans for any delays to a patients pathway	Maeve O'Callaghan-Harrington	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Daily performance meeting chaired by Director of Operations	Tina Benson	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Improved diagnostics 1. increased weekend working	Sean McCloy	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Improved diagnostics 2. increased CT and Ultrasound capacity	Sean McCloy	**Completed**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Improved diagnostics 3. cold elective work has moved to CMH to free capacity for NPH	Sean McCloy	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Improved diagnostics 4. Pilot of an Acute imaging team which has improved turn-around times for acute imaging	Sean McCloy	**Completed**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	Improved diagnostics 5. Endoscopy moved to 3 sessions a day	Sean McCloy	**Completed**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Weekend Discharges. Improve patient flow and avoid congestion and delays in A&E	Tina Benson	**Complete. Improved to meet weekend predicted discharges**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Increased consultant cover (subject to locum recruitment) as part of the Acute Medical Take with effect from the end of June 2013. Increased capacity to support flow and discharges	Tina Benson, Claire Walker	**Completed**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	New and established discharge policy. Increased capacity to support flow and discharges	Nipa Shah, Margaret Magee	**Completed**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Internal Professional Standards for all wards which includes standards for ward and board rounds, discharge from hospital, diagnostic response, OT and Physio. Increased capacity to support flow and discharges	All Heads of Department	**Completed**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Well established fit for purpose discharge lounge. Increased capacity to support flow and discharges	Ruth Cross	**Completed**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Established Discharge Partnership Board. Increased capacity to support flow and discharges	Maeve O'Callaghan-Harrington	**Completed**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Weekly review of patients with Length of Stay greater than 20 days. Increased capacity to support flow and discharges	Maeve O'Callaghan-Harrington, Rory Shaw	**Completed**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Implementation of additional discharge support social care staffing (Harrow). Support patient flow via Section 256 funding	Thom Wilson		16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Brent and Harrow CCGs to implement the agreed 48hr DTOC process. Increased capacity to support flow and discharges	CCGs		16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action taken	Date opened	Deadline
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Joint dispute resolution policy agreed between Brent CCG and Brent Council. Increased capacity to support flow and discharges	Jo Ohlson, Phil Porter	**Long standing agreement in place**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Increase patient flow through Willesden Community beds through seven day therapy provision. Increase community bed utilisation to build system capacity	James Walters, Ealing ICO	**Complete – planned extension to end July**	16/10/2013	2/12/2013
3. Improved discharge performance (Stage C: Discharge and Out of Hospital Care)	Uplifting ICO Harrow community rehab bedded unit block to increase substantive staffing. Reduce LOS for acute beds	Jason Antrobus, Rebecca Wellburn, Dr Genevieve Small	**In progress.** **In place through locums. Community Care now has additional locums.**	16/10/2013	2/12/2013

- **A lack of specific services available to acute trusts in a timely fashion for certain specific patient groups, such as those with mental health, alcohol or drug abuse problems.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
5. Improving care for key groups	Reduction in the length of time Mental Health patients waiting for beds. To improve access to emergency mental health treatment for patients. To reduce risks of patients harming themselves and others whilst waiting for admission.	Shaun Hare	**Fortnightly Senior Management meetings between CNWL , NWLH and Commissioners**	16/10/2013	2/12/2013
5. Improving care for key groups	Reduction in the length of time Mental Health patients await Mental Health Act Assessment delays awaiting an AMP. To improve access to emergency mental health treatment for patients. To reduce risks of patients harming themselves and others whilst waiting for admission.	Shaun Hare	**Escalation procedure in place between CNWL / EDT and Las enhanced AMHP included in winter monies. Integrated approach to Section 136 mgt**	16/10/2013	2/12/2013
5. Improving care for key groups	Reduction in length of time for a CAMHS assessment. Improving the experience of CAMHS patients. Avoid unnecessary delays for CAMHS patients.	Jackie Shaw	**Revised escalation procedures in place.**	16/10/2013	2/12/2013
5. Improving care for key groups	Reduction in length of time for a child to be admitted to another provider (Tier 4 Beds). To improve access to emergency treatment for CAMHS patients. Improving the experience of CAMHS patients.	Jackie Shaw	**Agreed Tier 4 access procedure in place CNWL/NHSE.**	16/10/2013	2/12/2013

Subject	Issue/Action	Action Owner	Action Taken	Date Opened	Deadline
5. Improving care for key groups	Continued funding of Psychiatric Liaison service. Reconfiguration of existing A&E Liaison services at the Central Middlesex Hospital site to the Northwick Park Hospital site to expand the current A&E/Psychiatric Liaison service there to ensure that demand and capacity are aligned. More equitable access to psychiatric liaison services in the south of the borough Reduction in avoidable admissions due to mental health problems Reduction in length of stay due to mental health problems being identified A pathway between psychiatric liaison at the Urgent Care Centre at the CMH site to reduce activity levels in view of reduced presentations at this site.	Sarah Mansuralli, Katrina Anderson	**In place**	16/10/2013	2/12/2013
5. Improving care for key groups	Prevent frequent attendees at A&E from re-attending. Prevent re-attendance		**CNWL to ensure all frequent attenders to A&E have appropriate crisis management plans to prevent re-attendance.** **Updates on number of patients reviewed each month provided by CNWL.**	16/10/2013	2/12/2013

Subject	Issue/Action	Action Owner	Action Taken	Date Opened	Deadline
5. Improving care for key groups	Expediate referral treatments for patients. Improve access to emergency Mental Health treatment for patients	Maeve O'Callaghan-Harrison Shaun O'Hare	**CNWL and NWLHT to develop a clinical protocol to expediate referrals for patients with no physical conditions.**	16/10/2013	2/12/2013
5. Improving care for key groups	Improve access to specialist pathway for Mental Health patients.		**CNWL to engage with harrow CCG re Personality Disorder pathway to implement pathway.**	16/10/2013	2/12/2013
5. Improving care for key groups	Improve out of hours mental health pathway. Reduction in length of time mental health patients waiting in out of hours. Reduce risk of patients harming self and others while waiting for A&E attention.	Shaun O'Hare Gary Passaway Helen Byrne Katrina Anderson	**Improve access to Mental Health treatment for patients by reviewing UCC and out of hours Mental Health pathway at CMH**	16/10/2013	2/12/2013
5. Improving care for key groups	Carers aware GP practice LES. To support carers in the community and reduce attendances and admissions		**Developing**	16/10/2013	2/12/2013
5. Improving care for key groups	Carers aware GP practice LES. To support GP's to identify hidden carers and offer support and intervention at an earlier stage.	Sarah Mansuralli, Katrina Anderson	**Developing**	16/10/2013	2/12/2013

Subject	Issue/Action	Action Owner	Action Taken	Date Opened	Deadline
5. Improving care for key groups	Commissioned falls service for Brent and Harrow. Reduce risk patients falling causing increased pressure on acute service and providing on-going support	Claire Walker, Sarah Mansuralli	**In place via STARRS schemes. There is a delay in the Brent Falls Business Case. SM to update on the timescale for the BC to be approved. Brent going through approval of Business Case - at next QIPP subcommittee 4th September and CCG Execs 11th September.**	16/10/2013	2/12/2013
5. Improving care for key groups	Reduction in length of time for detoxified patients to wait in A&E. To improve access to emergency detox services for patients. Re-education of risk of patients harming self and others while waiting for admission.		**There are 93-125 A&E attendances per month.**	16/10/2013	2/12/2013
5. Improving care for key groups	Improved care pathways including follow up in Primary Care. Reconfigured memory service to support increased numbers of people receiving an early diagnosis of Dementia. Development of an integrated pathway for people with dementia to improve the capability and capacity of primary care to better and reduce unnecessary and routine follow up care by secondary care. Increase early diagnosis to support earlier intervention and improved outcomes.	Katrina Anderson	**Business Case in process of being sent to Brent Exec for sign off.**	16/10/2013	2/12/2013

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
5. Improving care for key groups	Carers with 'moderate needs' provided with funding for respite care. To intervene at an earlier stage to support carers who would not receive support from social care to access respite funding with the aim of preventing breakdown in the caring role.	Katrina Anderson	**Update required.**	16/10/2013	2/12/2013
5. Improving care for key groups	To support primary Care in the early identification and assessment of the needs of carers who do not meet the local authority FACS criteria for services. To offer early intervention to carers with moderate needs. To avoid breakdown in the caring situation. To prevent avoidable emergency admissions	Katrina Anderson	**Update required.**	16/10/2013	2/12/2013
5. Improving care for key groups	Reduce conveyed incident call outs to London Ambulance Service. Better planning and out of hours support will ease pressure on LAS and help care homes manage.	Sheik Auladin	**Update required.**	16/10/2013	2/12/2013
5. Improving care for key groups	Reduce hospital admissions/readmissions. Reduce distress for residents and financial savings.	Sheik Auladin	**Update required.**	16/10/2013	2/12/2013
5. Improving care for key groups	Improve assessment for new residents. To ensure patients are admitted to the right care home for their specific needs.	Sheik Auladin	**Update required.**	16/10/2013	2/12/2013
5. Improving care for key groups	Standardise anticipatory care planning throughout Harrow Care Homes. To ensure all Harrow residents receive an equal standard of care.	Sheik Auladin	**Update required.**	16/10/2013	2/12/2013

Subject	Issue/Action	Action Owner	Action Taken	Date Opened	Deadline
5. Improving care for key groups	Medicines review for priority residents. To ensure medications are up to date and in line with NICE.	Sheik Auladin	**Update required.**	16/10/2013	2/12/2013

- **More delayed discharges because primary, community or social care services are not place.**
- **Perceived lack of availability of primary care and community services, especially out of hours.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Brent Primary Care Access Pilot. Extra ~ 8% capacity into Primary Care by having the equivalent of x 5 GP practices open from 3pm to 9pm Mon - Fri and 9am to 9pm on Sat	Dr Ethie Kong Sarah German	**In place in all 5 localities.**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Brent primary care performance normalisation. Target the lowest performing 20% of practices and aims to improve individual performance to meet local (London) averages.	NHS England, Sarah Mansuralli	**Review performance 2/12/2013.**	16/10/2013	2/12/2013
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Primary care referral management local enhanced service. Reduce inappropriate emergency activity.	Rebecca Wellburn, Sarah Mansuralli.	**Review performance 2/12/2013.**	16/10/2013	2/12/2013

Subject	Issue/Action	Action Owner	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	Out of Hours quality review for opted out practices only. Remit for opted in practices lies with NHS England. NWL CSU has recently taken on the contract support function for NW London OOH contracts, and a review of current contracts is underway to map them against National Quality Requirements in the Delivery of Out-of-hours Services (Department of Health, July 2006 Gateway no. 6893)	Frankie Lynch (CSU) Stephen Dixon Bernard Quinn	**What is the process/solution going forward for opted out GPs? BQ will check with NHSE to see if there are suitable governance arrangements. BQ will try and get hold of the letter. SD to get the CSU to give feedback on their actions.**	30/10/2013	2/12/2013

- **A lower threshold in hospitals for admitting or discharging patients to ensure safety standards. In some cases, this is perceived to be linked to the seniority of the workforce in A&E.**

- **The Francis report and its impact on clinical decision making thresholds.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
4. Patient experience and safeguarding	To achieve national 15% response target rate for Friends &Family Test in A&E. To ensure patients are offered the opportunity to provide feedback on their experience.	Carole Flowers, Ursula Gallagher	**Reported at Board level.**	16/10/2013	2/12/2013
4. Patient experience and safeguarding	To ensure compliance with training and recording for Safeguarding Children. To ensure that all relevant staff receives the appropriate level of training and data is retrievable from OLM.	Carole Flowers	**Reported at Board level.**	16/10/2013	2/12/2013

Subject	Issue/Action	Action Owner	Action Taken	Date Opened	Deadline
4. Patient experience and safeguarding	Updating of policies and guidelines to ensure robust governance arrangements in relation to HR policy, volunteers and Safer Recruitment and managing allegations against staff. To ensure robust governance arrangements clearly communicated to all staff and regularly audited.	Carole Flowers	**Reported at Board level.**	16/10/2013	2/12/2013
4. Patient experience and safeguarding	To update complaints policy for NWLHT and CCG in line with Francis and to ensure close engagement of patients and lay people in the process Complaints to be filtered and actions to address key issues to be fed back into action plan. To ensure that the expectations of patients in respect of the quality of care that they receive from commissioned services are addressed and new actions fed back into action plan.	Carole Flowers	**Reported at Board level.**	16/10/2013	2/12/2013
4. Patient experience and safeguarding	To develop early warning system with an escalation process that triggers any interventions at the appropriate time and level. To ensure intervention and sanctions for substandard or unsafe services and to provide a revised approach to performance information and intelligence.	Ursula Gallagher	**Reported at Board level.**	16/10/2013	2/12/2013
4. Patient experience and safeguarding	To review quality standards for all contracts in respect of patient experience, complaints, patient safety and serious incidents. To ensure that the fundamental patient safety and quality standards are being met and to feed these into the new commissioning round and future specifications.	Ursula Gallagher / Bernard Quinn	**Reported at Board level.**	16/10/2013	2/12/2013

- **Reduction in bed numbers and staff as hospitals try to deliver cost improvement plans.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	NWLHT to evaluate building works which would expand bed capacity by a further 40 beds based on the outputs of the demand and capacity modelling. To understand the capacity requirements in preparation for winter 2013/14.	Tina Benson, Rory Shaw	**Completed.**	16/10/2013	2/12/2013
2. Improving acute flow and bed capacity (Stage B: Patient journey through the Hospital system)	To agree actions and resources across the health economy based on the recommendation of the demand and capacity review. To confirm the capacity requirements in preparation for winter 2013/14.	Bernard Quinn, Tina Benson, NWLHT Board, CCG GBs	**Completed**	16/10/2013	2/12/2013

- **Lack of focus during transition for commissioners and uncertainty about changing roles in the new system.**
- **Pressure on social care budgets.**
- **Introduction of NHS 111.**

Subject	Issue/Action	To be Actioned by	Action Taken	Date Opened	Deadline
1. Admission avoidance pathway development (Stage A: Prior to A&E)	111 implementation. To redirect appropriate patients away from acute settings	Jason Antrobus, Dr Mo Ali, Dr Cherry Armstrong	**Completed**	16/10/2013	2/12/2013

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Brent	**Health Partnerships Overview and Scrutiny Committee** 4th December 2013 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Brent CCG "Wave 2" Commissioning: Impact Assessment and Consultation Plans

1.0 Summary

1.1 The Health Partnerships Overview and Scrutiny committee will be aware that Brent Clinical Commissioning Group is about to undertake "Wave 2" of its procurement plans. Wave 2 procurement covers the re-procurement of musculoskeletal services, trauma and orthopaedics, rheumatology and gynaecology. The CCG will be using consultants Mott MacDonald to undertake both an impact assessment and the statutory consultation for this procurement and the proposals for both of these are now being presented to the committee.

1.2 The impact assessment will cover four key areas: a health impact assessment, an equality impact assessment, a travel and access impact assessment and an organisational impact assessment. The stakeholders and the key lines of enquiry for each are included in the attached report. The report that results from the impact assessment will include recommendations to mitigate any negative impacts that are identified.

1.3 The consultation will primarily consist of consultation events, an online survey and focus groups with key patient and hard to reach groups. There will also be a consultation booklet produced. In addition to this consultation a further consultation will take place at a later date on the actual service specifications for each of the four services.

2.0 Recommendations

2.1 The committee is recommended to question officers from the CCG on the planned impact assessments and consultation to establish if they are sufficient and robust, and to recommend improvements or additional measures if necessary.

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Report to:	Brent Health Partnerships Overview and Scrutiny Committee (OSC)
Report from:	NHS Brent CCG
Date of meeting:	4th December 2013 (Health Partnerships OSC)
Re:	**Wave 2 Outpatient Procurement Update on Consultation Plan and Integrated Impact Assessment**

1. Purpose of the Report

1.1 This report provides proposals for the public consultation action plan and information about the process to be employed to undertake the integrated impact assessment as well as the deliverables of this assessment with respect to Wave 2 procurement specialities; musculoskeletal services and gynaecology.

1.2 There are two papers attached, provided by Mott MacDonald, who have been awarded the contract to undertake the integrated impact assessment and formal public consultation for wave 2 procurement specialities. These papers provide the action plan for each component.

2. Case for Change

2.1 NHS Brent CCG has emphasised that its mission is to:

- Commission services that improve the health and wellbeing of all patients registered with its member practices and those who are unregistered but are resident in the London Borough of Brent.
- Secure sustainable care that enables Brent patients to receive modern, responsive, high quality yet cost effective care
- Ensure that these services are effectively commissioned within the CCG's financial resource limits. NHS Brent CCG's mission is based on an aspiration to reduce health inequalities within the communities that make up Brent's diverse population.

2.2 There are three main challenges for Brent that mean how health care in the borough is delivered needs to change:

- The residents of Brent have changing health needs, as people live longer and live with more chronic and lifestyle diseases – putting pressure on social and community care.
- Under our current model of care, we cannot afford to meet future demand. We need to have more planned care, provided earlier to our population in settings outside of hospital. This should provide better outcomes for patients, at lower cost and in line with best practice guidance. MSK services have been redeveloped nationally to offer the integrated care pathway that Brent CCG wishes to commission, in order to streamline service delivery, improve patient experience and outcomes and reduce duplication.

- In addition, a gynaecology pathway has been piloted in two of the five localities in Brent over 2013-14. The pathway spans primary and secondary care and has achieved improved clinical outcomes, a more expedient/responsive service as well as a more efficient pathway for gynaecology services.

3. Integrated Impact Assessment

3.1 In line with the requirements of the contract, the integrated impact assessment will provide the following deliverables:

- Health impact assessment (HIA) - assessing the proposals in relation to health outcomes, health inequalities and quality of care;
- Equality impact assessment (EqIA) – assessing the proposals in relation to the statutory groups with protected characteristics as defined within the Public Sector Equality Duty as well as other vulnerable groups;
- Travel and access impact assessment – assessing the accessibility of current services and existing travel inequalities; and
- Organisational impact assessment – assessing the impact of the proposals on current service providers in terms of clinical viability and financial sustainability.

3.2 Integrating these impact assessments into one avoids duplication and consultation fatigue. It also strengthens the quality and depth of analysis considerably because impacts can be linked together, allowing the consideration of synergistic or cumulative effects on populations and communities.

3.3 The outputs from the impact assessments will be available in advance of the public consultation process whilst the final deliverable will be completed following the public consultation. Outputs include:

- Pre-consultation scoping report setting out the context for the review, details of the changes in service proposals and identifies those populations and equality groups who have a higher propensity to use the services under review and therefore need a particular focus of attention going forward (timescale for completion 29th November 2013)

- Pre-consultation impact assessment report setting out the findings from engagement forums with patient and public representatives and other key stakeholders, which explores the positive and negative impacts arising from the changes. In addition the report will include analysis of travel time to current acute hospital sites to understand impact of providing services from community based locations and assessment of impact on providers in terms of clinical interdependencies, sustainability of clinical services and financial viability.

- Post-consultation integrated impact assessment report setting out the findings from the formal consultation process which will assess relevant impacts on statutory equality groups with recommendations and mitigations for inclusion in service specifications.

4. Formal Public Consultation Plan

4.1 The CCG has commissioned Mott MacDonald to facilitate a three month formal public consultation programme in addition to the integrated impact assessment.

4.2 The approach to this formal public consultation combines a range of activities comprising the following key tasks:

- Consultation events x 6
- Online survey
- Deliberative focus groups

4.3 It is important to note that subsequent consultation on the draft specification will take place from April 2014 and is not form part of the present scope of work detailed in the attached public consultation action plan.

4.4 To support the formal public consultation, the CCG and Mott MacDonald will produce a consultation booklet, outlining the proposed changes, case for change and advertising dates/locations of public exhibitions and road shows as well as a questionnaire with freepost return envelope.

4.5 The online survey will be designed to elicit qualitative and quantitative feedback on the proposed services changes. Mott MacDonald will design and administer this online survey which will use the same questions as the paper questionnaire included in the consultation booklet.

4.6 The public consultation events will be supplemented by up to six deliberative focus groups, targeting across section of the community. The balance of each focus group will be informed by the Integrated Impact Assessment scoping report in terms of population profiling tasks and identification of those from protected groups who are most likely to be affected by the proposed service changes.

5. Timescales

5. Timescales for the public consultation and integrated impact assessment are in line with the timescales presented to the Health Partnerships OSC in September 2013.

Timescale	Activity

November to Mar 2014	• Integrated impact assessment starts with strategic engagement phase of integrated impact assessment
	  ○ Pre consultation scoping report – 29/11/13
	  ○ Pre-consultation impact assessment – 20/12/13
	  ○ Post consultation impact assessment – 18/4/13

Jan to March 2014	• Formal consultation and engagement starts with providers, patients, the public and partners ○ As per formal public consultation action plan (attached)
Feb to May 2014	• Procurement process via competitive dialogue starts • Discussing with potential providers services that could be provided in the community that would provide high quality outcomes for patients, enable integrated services and encourages effective partnership with patients and their GPs
April 2014	• Consultation on draft specification with patients, partners and public
May 2014	• Successful bidders selected
June to Sept 2014	• Mobilisation phase which includes: • working with the new provider on establishing the new service • informing patients about the new arrangements • ensuring safe and seamless transfer of care

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Integrated Impact Assessment

Introduction

To support the commissioning intentions for Wave 2 of its outpatient specialities, the CCG has commissioned a review to assess the potential impacts of these changes. Understanding how proposed changes to healthcare services would affect current and future patients, the wider public and providers will be important considerations in the decision making process. These effects could materialise in terms of positive or negative impacts on, for example, the quality of care and patient outcomes, travel and access to services, sustainability of service providers, etc.

One particular recognised mechanism aimed at providing a logical process to identifying and appraising the range of impacts is an impact assessment. Impact assessments are a key component of policy and investment evaluations undertaken by all UK Government departments and agencies. Over the past few years as the NHS has embarked on major service reconfiguration, the need for impact assessments in the healthcare sector has become increasingly more apparent.

NHS Brent CCG has opted to undertake a number of impact assessments in one integrated package. This package comprises:

- Health impact assessment (HIA) - assessing the proposals in relation to health outcomes, health inequalities and quality of care;
- Equality impact assessment (EqIA) – assessing the proposals in relation to the statutory groups with protected characteristics as defined within the Public Sector Equality Duty as well as other vulnerable groups;
- Travel and access impact assessment – assessing the accessibility of current services and existing travel inequalities; and
- Organisational impact assessment – assessing the impact of the proposals on current service providers in terms of clinical viability and financial sustainability.

Integrating these impact assessments into one avoids duplication and consultation fatigue. It also strengthens the quality and depth of analysis considerably because impacts can be linked together, allowing the consideration of synergistic or cumulative effects on populations and communities.

Following a competitive tendering process, Mott MacDonald has been selected to deliver this.

The Deliverables

Three deliverables have been defined as outputs to this process. The first two of these will be available in advance of the public consultation process whilst the final deliverable will be completed following the public consultation process. All deliverables will take the form of written reports.

A key component across the assessment is the engagement with a range of clinical and service stakeholders, key interest patient groups, equality groups and patient representatives. Views

gathered through this engagement process form a critical part of the analysis, findings and recommendations.

Detailed below is the process plan for when and how these deliverables will be completed.

Pre-consultation Scoping Report (Deadline 29th November 2013)

This initial report sets the context for the review, the details of changes in service proposals and identifies those population and equality groups who have a higher propensity to use the services under review and, therefore, need a particular focus of attention going forward.

This stage of work is largely undertaken as a desktop exercise; reviewing background documents, information on future model of care and service volumes; and the review of evidence on prevalence, service use, health outcomes and health inequalities across the population and those with protected characteristics. An important component of this stage is a strategic engagement programme which involves individual interviews with key stakeholders including:

- CCG Clinical Lead;
- Public Health;
- Healthwatch;
- The Directors of Strategy from the current providers.

We will begin the programme of individual interviews within this first phase but recognise that not all of these may have been completed before submission of the Scoping Report; therefore they will be undertaken within the next phase of work. In Appendix A, we have provided an outline of the questions which will have been incorporated into the topic guide which informs these individual interviews. The final task within the stage will be to complete socio-demographic mapping of the identified key equality groups across Brent and, in particular, those identified through the evidence review who have a higher propensity to use these service.

Pre-consultation Integrated Impact Assessment Report (20th December 2013)

This is the deliverable of the IIA process that will be used to inform the public consultation. This will include:

- Findings from engagement forums with patient and public representatives and other key stakeholders. These will explore the positive and negative impacts arising from the proposed changes and highlight suggested opportunities for mitigation actions to reduce adverse impacts. Two IIA engagement forums will be arranged for early December (provisionally booked for 17th December 2013), one for Gynaecology and one for MSK, Rheumatology and Trauma and Orthopaedics. Mott MacDonald are liaising with the Equality and Communication Leads of the CCG to develop the invite list and invites will be issued shortly;
- Follow up individual interviews with any representatives not able to join the forums but who would like to contribute to the process;

- Analysis of travel time to current acute hospital sites to understand impact of providing services from community based locations; and
- Assessment of the impacts on providers in terms of clinical interdependencies, sustainability of clinical services and financial viability.

The impacts identified from this stage will be documented within a single report and will address the overall impacts on health outcomes and inequalities, equality, access, financial and clinical interdependencies, travel and access. Each impact identified will be appraised using agreed criteria including magnitude, likelihood and duration of the impact.

The final chapter of the report will document a set of recommendations that look to maximise the positive impacts and mitigate any potential adverse effects. These will also support the development of the specification for procurement.

Post-consultation Integrated Impact Assessment (18th April 2014)

Following the formal public consultation process, the findings from this will be reviewed and any relevant impacts (particularly on the statutory equality groups) which have not yet been identified will be incorporated into the final report.

Any additional recommendations or mitigations will also be incorporated into the report and noted for inclusion in the service specifications.

Appendix A: Outline of Integrated Impact Assessment Topic Guide for individual interviews

Topic Guide for the Clinical Lead:

Current Provision
Q1: Please describe the context of current outpatient service provision for these 4 specialties (trauma and orthopaedics, musculoskeletal, rheumatology and gynaecology services)? How are services currently delivered by the two current providers (North West London Hospitals and Imperial College)?
Q2: Please describe typical activity trends for these specialties?
Q3: What do you feel are the challenges and issues with the current provision of the four outpatient specialties under review? (4 specialties)
Q4: Who uses these services and what are the needs of the population?
Newly commissioned outpatient provision
Q5: How do you see outpatient services changing as a result of QIPP and the Brent Out of Hospital Strategy?
Q6: How do you see services changing as a result of the competitive re-procurement?
Q7: Where will newly commissioned services be delivered? How local will this be compared to current provision on acute hospital sites?
Impacts
Q8: What impact will the future model of care and referral management centre have on referrals and activity?
Q9: How are savings to be delivered?
Q10: What do you consider to be the impact on (current and future) providers?
Q11: What do you think are the potential benefits of the re-procured services likely to be on patients and the health economy?
Q12: Do you think the benefits you have identified are dependent on other factors? How important are these factors to the delivery of outpatient services in the future?
Q13: What do you think the potential negative impacts of the re-procured services could be (for patients and the public, and the health economy)?
Q14: Do you think that the proposed change to services will provide particular benefits or disbenefits to any groups within the local population?
Q15: How do you feel that the proposed change to services will help to address existing health inequalities?
Q16: Are there any ways in which some of the negative impacts that have been identified can be mitigated?
Q17: Do you feel that the changes could be improved in any way? If so, how?
Q18: Are there any key individuals / stakeholders that we should be talking to as part of this impact assessment?
Q19: Is there any specific evidence or local work that you are aware of which we should consider as part of the impact assessment?

Topic Guide for the Director of Public Health, Healthwatch Brent representatives, CVS lead

Current Provision
Q1: What do you feel are the challenges and issues with the current provision of the four outpatient specialties under review? (4 specialties)
Impacts
Q2: What do you think are the potential benefits of Out of Hospital development initiatives and the re-procured outpatient services are likely to be?
Q3: Do you think the benefits you have identified are dependent on other factors, and how important are these factors to the successful delivery of services in the future?
Q4: What do you think the potential negative impacts of the re-procured services could be?
Q5: Do you think that the proposed change to services will provide particular benefits or disbenefits to any groups within the local population? What are the needs of the population for these services?
Q6: How do you feel that the proposed change to services will help to address existing health inequalities?
Q7: Are there any ways in which some of the negative impacts that have been identified can be mitigated?
Q8: Do you feel that the changes could be improved in any way? If so, how?
Q9: Are there any key individuals / stakeholders that we should be talking to as part of this impact assessment?
Q10: Is there any specific evidence or local work that you are aware of which we should consider as part of the impact assessment?
Q11: Do you have any other comments?

Topic guide for current providers:

Current Provision
Q1: Please describe the provision of current outpatient services for these 4 specialties, including the location from which they are current provided?
Q2: Please describe typical activity for these specialties?
Q3: Operationally, how are services currently delivered and what resources do they utilise?
Q4: What do you feel are the challenges and issues with the current provision of the four outpatient specialties under review? (4 specialties)
Impact of newly commissioned outpatient provision on current provider, assuming they are successful in the competitive procurement process
Q5: How will the hospital and Trust be impacted should they be successful in the competitive procurement to provide these outpatient services in line with the new specification?
Impact of newly commissioned outpatient provision on providers, assuming they are unsuccessful in the competitive procurement process
Q6: How will the clinically interdependent services you retain (e.g. the inpatient component of these specialties) be impacted should a new provider provide the outpatient component of care?
Q7: What will be the wider impacts on the Trust?
Q8: Will any of these wider impacts be increased further through other changes planned by neighbouring CCGs or Trusts?
Q9: What do you consider to be the key challenges in implementing the re-procured services?
Wider Impacts
Q10: What do you think are the potential benefits of the re-procured services likely to be on patients and the health economy?
Q11: Do you think the benefits you have identified are dependent on other factors, and how important are these factors to the successful delivery of services in the future?
Q12: What do you think the potential negative impacts of the re-procured services could be (for patients and the public, and the health economy)?
Q13: Do you think that the proposed change to services will provide particular benefits or disbenefits to any groups within the local population?
Q14: How do you feel that the proposed change to services will help to address existing health inequalities?
Q15: Are there any ways in which some of the negative impacts that have been identified can be mitigated?
Q16: Do you feel that the changes could be improved in any way? If so, how?
Q17: Are there any key individuals / stakeholders that we should be talking to as part of this impact assessment?
Q18: Is there any specific evidence or local work that you are aware of which we should consider as part of the impact assessment?

Public Consultation Action Plan

Introduction

NHS Brent Clinical Commissioning Group (CCG) is undertaking a programme of work to change the shape of service provision and intend to commission services that are patient-centred developed through improved pathways of care, and deliver the best health outcomes. As part of this programme, the CCG is undertaking a programme to re-commission some outpatient specialities. This is the second wave of specialities being considered for re-procurement and includes the following outpatient specialties: Musculoskeletal Services; Trauma & Orthopaedics; Rheumatology; and Gynaecology.

In supporting how these re-procured services should be delivered, the CCG is keen to elicit the views of patients and the public, together with other key stakeholders. We are keen to engage them in a programme of consultation which effectively reaches out across different population groups within the borough through a programme of consultation events which are proportionate to the proposed changes and in line with its statutory obligations.

The CCG has commissioned Mott MacDonald to facilitate a 3 month formal public consultation programme, in addition to the Integrated Impact Assessment.

The purpose of this document is to outline Mott MacDonald's plans to consult with the community on the proposed service changes. These plans will be updated and developed as the project progresses. However, in summary, the approach combines a range of activities designed for effective engagement and comprises the following key tasks:

- Consultation events;
- Online survey; and
- Deliberative focus groups with key patient groups/hard to reach groups.

It is important to note that a subsequent consultation on the draft specification will take place from April 2014. This does not form part of the present scope of work.

Consultation Events

Consultation events, held in public spaces across Brent, will be used to promote the CCG's proposals and to encourage the wider public to provide their comments and views on these via survey questionnaires.

In total 6 public consultation events will take place between January and March 2014, incorporating:

- A permanent (non-staffed) public exhibition for the duration of the consultation period. Six A1 PVC boards outlining the service changes and how to take part in the consultation will be on display in a public space (such as a civic centre);
- One staffed public exhibition day using the same materials as set out for the non-staffed public exhibition; and
- Five staffed community road show events will take place in each of the five Brent districts. The road show events will use the same materials as the public exhibition and will take place for one day in each locality in either a retail area (shopping centre etc.) or public space (library etc.). NHS

Brent CCG and Mott MacDonald staff will attend each event to facilitate discussion and feedback, distribute the leaflet/questionnaire and promote the online survey.

The public exhibition/road shows will use two-way channels of communication to promote a 'display, discuss, and decide' approach with the attendees. At these events, representation will include both Brent CCG clinical or programme staff in order to explain the proposals and answer questions. Mott MacDonald staff will also be on hand to encourage the public to engage with the consultation either in-situ using the display boards and public consultation booklet or by directing them to the online survey and NHS Brent CCG website.

The exact locations of each event are to be advised by NHS Brent CCG and through linking in with Healthwatch Brent and the local patient and public engagement groups. All locations will be in areas of high footfall and the events will take place on weekends to ensure that an appropriate cross section of the wider and local communities can attend the events.

Mott MacDonald will book each event and design and print the relevant materials.

Table 1.1 – Overview of Consultation Events

Type	Location(s)	Venue	Date	Duration	Staffed	Materials	Target Demographic Group
Non-staffed public exhibition	Central Brent Area	Public space – i.e. civic centre, town hall, library, community centre etc. (TBC)	January – March 2014	Permanent for 3 months (TBC)	Non-staffed	6 x A1 PVC Boards Consultation booklet / questionnaire at each event	Wider community
5 x community road shows	Harness Kilburn Kingsbury Wembley Willesden	Retail space e.g. shopping centre or public space e.g. civic centre, town hall, library, community centre. A location with high footfall.	January - March 2014	1 day per event	Full 1-2 x NHS Brent CCG 1 x MM	6 x A1 PVC Boards Consultation booklet / questionnaire at each event	Local community
Staffed public exhibition	Central Brent Area	This will be held at the same location as the permanent public exhibition above.	March 2014	1 day	Full 1-2 x NHS Brent CCG 1 x MM	6 x A1 PVC Boards Consultation booklet / questionnaire at each event	Wider community

Consultation Materials

In collaboration with the CCG, Mott MacDonald will produce a consultation booklet. This booklet will include up to 8 A5 pages outlining the proposed service changes, including the case for change, advertising the dates/locations of the public exhibitions / road shows, and a questionnaire and freepost return envelope that can be detached from the booklet. A Quick Response Code (QR) code and link to an online survey will also be included (a QR code allows smart phone users to scan an image to automatically be routed to the online survey website). We will use existing mailing lists of the CCG to initially issue the consultation booklet.

Copies of the consultation booklet will be available at the public exhibition / road shows. At each public exhibition / road show, 6 x A1 PVC boards will be used to summarise the proposed service changes and outline how the public can respond / feedback their views.

Publicity

The dates and locations of the public exhibitions / road shows will be advertised on the NHS Brent CCG website and in the local press, for example, a half page advert will be placed in the Kilburn / Harrow Times etc. This will ensure that the general public in the Brent area are well informed of the consultation.

We will also engage with key community, service user and stakeholder groups to ensure that representative groups (such as Healthwatch Brent etc.) are made aware of the consultation events and are given the opportunity to cascade information to their members. Alternatively, they will be able to submit a collective response to the consultation questions.

Online Survey

An online survey will be designed to elicit quantitative and qualitative feedback on the proposed service changes. Mott MacDonald will design and administer this online survey which will use the same questions as the paper questionnaire (contained in the consultation booklet). Those attending the public consultation events and/or in receipt of a public consultation booklet will be encouraged to complete the online survey. The survey link will also be publicised on the CCG website, in the various newspaper adverts and via community, service user and stakeholder groups.

The online survey will also collect demographic information so that it is possible to analyse results by geography and by different population groups.

We will also use existing email mailing lists provided by NHS Brent CCG and/or the various community, service user and stakeholder groups to raise awareness of the consultation. A covering email will be sent providing a brief overview of the consultation with links to the relevant area of the CCG website and a link to the online survey.

Upon receipt of any email contact lists, care will be taken to ensure the details are appropriate for such use, in line with the Data Protection Act.

Focus Groups

The public consultation events will be supplemented by up to six deliberative focus groups, targeting a cross section of the community. These deliberative focus groups will be conducted in parallel to the consultation events.

The balance of each focus group will be informed by the Integrated Impact Assessment scoping report in terms of population profiling tasks and identification of those from protected groups who are most likely to be affected by the proposed service changes. Following the initial scoping report, a recruitment strategy will be produced that will detail the approach to recruiting respondents for the focus groups. The recruitment strategy is expected to utilise existing community, service user and stakeholder groups in addition to key community contacts in order to recruit members of the 'hard to reach' segments of community or specific types of service users, most likely to be affected by the proposed changes.

The focus groups will provide an opportunity for 'groups of interest' to consider the specific issues in detail and allow us to collect more detailed, qualitative feedback.

Table 2.1 – Overview of Focus Groups

Focus Group	Location	Venue	Date	Time	Participants	Target Demographic Group
Six	TBC	Hotel / library etc. (TBC)	January - March 2013	Evening	8 per group	TBC

Prior to the commencement of the focus groups the following preparation tasks are required:

Task	Comments
Identify target groups	Following the initial scoping report, Mott MacDonald (in discussion with the client team) will identify the particular groups for inclusion in the focus groups
Design and agree topic guide(s)	Using the same topic areas as the consultation questionnaire, Mott MacDonald will design a topic guide to elicit more detailed feedback on the proposed service changes and impacts on particular groups.
Design and agree recruitment strategy	Once the target groups have been agreed, Mott MacDonald will produce a recruitment strategy for each of the target groups.
Confirm focus group dates, venues and times	
Commence respondent recruitment	

Upon receipt of any email contact lists, care will be taken to ensure these are appropriate for such use, in line with the Data Protection Act.

Deliverables

Responses from all consultation sources will be triangulated into a concise public consultation report which will summarise the consultation responses in a way suitable for all interested audiences.

These findings will then be used to inform the details of the draft commissioning specification for these specialties, which will be then be subject to a further, separate consultation process.

Your support

In support of our preparation, **we would seek your assistance** in ensuring that we engage appropriately with known patient group representatives and other key contacts.

Please provide details to steven.marsh@mottmac.com

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Brent	**Health Partnerships Overview and Scrutiny Committee** 4th December 2013 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

NW London Hospitals: 18 Week Referral to Treatment Targets Incident

1.0 Summary

1.1 Members of the committee may be aware that patients have a right to receive consultant led treatment within 18 weeks of referral. The reports from North West London Hospitals highlights the fact that, in February this year, it was identified that 60% of patients on the waiting lists did not have an open care pathway, meaning that waiting times had been wrongly recorded and that, as a result, large number of patients had been waiting longer than 18 weeks and there was an unmanageable number of cases on the waiting list that could not be addressed through normal channels.

1.2 NHS IMAS (Interim Management and Support) were asked to review the problem and identified issues around:

- systems and processes;
- increased demand not met by capacity;
- culture and pressure on staff.

1.2 Actions are being taken to review processes. To address the immediate issue additional outpatient clinics have been added and a large number of cases (approx. 4000) are to be outsourced to other providers.

2.0 Recommendations

2.1 The committee is recommended to question representatives of North West London Hospitals Trust further on:

- exactly how the issues arose;
- the long term actions being taken to address the systemic issues;
- the immediate actions being taken to address the immediate issues;
- the level of impact this has had on the health of affected patients.

Contact Officers

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Update for Brent Overview and Scrutiny Committee – December 2013

18 Week Referral to Treatment Target

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1. Purpose

The purpose of this paper is to provide an update for the Committee on the significant challenges faced by the Trust in relation to the 18 week referral to treatment target (RTT) and the arising data quality issues within the organisation.

2. Introduction.

In February this year, during routine validation of inpatient waiting lists, it was noted that approximately 60% of patients on this list did not have an open 18 week pathway. This means that the entire length of wait; starting from the original referral from the GP was not being correctly counted. An internal investigation was undertaken as 60% was an unusually high number. However, the internal investigation did not reveal the reasons for the open pathway which led to the decision to request an external review. In May, NHS IMAS (interim management and support) from NHS England were invited to review processes and pathways underlying the 18 week referral to treatment pathway (RTT).

3. NHS IMAS Diagnostic Review

NHS IMAS undertook a diagnostic review in June and established that 2,700 patients on the in-patient waiting list had not had their entire wait recorded correctly. Half of these patients have been treated within 18 weeks; the vast majority of the remaining patients on the list have now been offered a date for treatment and those still waiting will be offered a date for treatment within the next week. The review also highlighted that 12 patients on the list had waited more than 52 weeks for their treatment. Clearly this is unacceptable and each of these patients has been contacted directly and treatment has been offered.

NHS IMAS provided feedback outlining the reasons for the problems. Their key findings fall into three main categories:

A. ***Systems and processes*.**
These were not sufficiently robust and there was not a consistent approach across all staff groups throughout the organisation. Standard procedures and common pathways were not available to the junior clerical staff to support their decision making.

B. *Capacity and demand*.
Over time demand for particular services had built up but without the necessary capacity in place, and the amount of care commissioned was insufficient. We are working with our clinical commissioning groups (CCGS) to resolve this.

C. ***Culture.***
There was a culture where some staff felt under pressure to stop patients' clock prematurely and therefore accurate waiting times were not recorded. While the external review highlighted cultural issues, there is no evidence that any staff member was deliberately mis-recording information. NHS IMAS found that all staff were very open and wanted to make sure that we as an organisation were doing the right thing for patients.

4. Patient Safety

No patients were denied treatment as they were all on the in-patient waiting list and would have been offered a date for treatment. The problem was that not all of their waiting time had been recorded so some had waited longer than we were aware of.

This affected patients across a range of specialties awaiting routine appointments but did not affect clinically urgent patients including cancer patients.

The Medical Director and Clinical Director for the specialty have undertaken an overview of those patients waiting for more than 18 weeks. GPs have also been sent individual lists of patients waiting over 18 weeks for admission and have been asked to raise any clinical concerns this may cause, so far there have been none. We have compared death rates with previous years and there have been no more deaths on the waiting list this year.

5. Communications

We have written and apologised to all patients who have waited longer than 18 weeks for treatment. The vast majority of patients have now been offered a date and we are working hard to ensure those remaining patients are given a date. If patients have any concerns about the next stage of their treatment, we have asked them to call an information line. To date, we have had 122 calls. , All but one patient had an appointment or was offered an appointment on the phone. The one remaining patient had had their treatment privately and no longer required treatment at our Trust. We have informed our local GPs and CCGs, in addition to other stakeholders such as NHS England, local Health watch, NHS Trust Development Authority, Care Quality Commission and local media.

6. Action

Working with our clinical commissioning groups (CCGs) and the IST we have produced a comprehensive action plan to address all the issues raised and this includes:

- Rewriting our access policy and ensuring that all staff have a good understanding of this. This also includes standard operating procedures for entering data onto our patient administration system.

- Updated our data recording and reporting. This is now monitored, audited and discussed on a weekly basis.

- Developing of common pathways. Clinical specialties are in the process of ensuring that they have common pathways in place which are clear to all members of our staff where the ‘clock starts’ and the ‘clock stops’ during a patient’s treatment, to ensure that our recording is accurate.

- Setting up outpatient additional clinics and operating lists. The Trust has put in significant additional outpatient clinics as well as operating/procedure lists in order to treat the 95% of patients not requiring an admission and 90% of patients who do require admission, within 18 weeks of referral from their general practitioner or community clinician. This means that there is a significant increase in activity across both our sites.

- Supporting our staff. All of the new policies and procedures support staff to do the right thing for patients in line with the 18 week pathway. Staff are encouraged to raise any issues about data recording with their direct line manager or another senior manager in the organisation.

- Outsourcing additional capacity to both alternative NHS providers and private providers of the patients' choice.

Patients continue to have the right to choose which hospital they would like to be treated as set out within the NHS Constitution.

7. Board assurance

This incident has been discussed at our Board and a report presented in our meeting which is held in public.

The quality of data concerns relates to the data which informs the Trust performance report, which assures the Board on a number of both performance and quality indicators.

The Director of IM&T is currently leading the data quality strategy for which performance data will now be included in the light of the issue we have had with 18 weeks. The first stage of this is a third party audit. The scope of this audit will include an overall review of the Trust's governance, standards, processes, controls and reporting in respect of data quality management, together with specific data audit checks in relation to A&E, Cancer and 6 Week Diagnostics RTT national indicators. This audit work will be completed in November and December, with a final report to be signed off in January 2014.

8. Audits

Previous audits have shown A&E data to have been of good quality and this is validated and updated on a daily basis by the A&E management team. Cleary the board needs to be assured that other data is of a good quality.

Conclusion

The progress against the Trust action plan is being monitored at a fortnightly steering group and at the subcommittee of the board with an exception report to the main Trust board. In addition an independent data quality audit has been commissioned and this is expected to report in January 2014.

Tina Benson
Director of Operations
18th November 2013

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North West London Hospitals Trust

18 week RTT Outsourcing proposal

1.0 Background

The Trust is currently working through an improvement programme for 18 weeks, which started with an IST diagnostic review in June 2013. Part of the work carried out by the Trust and IST identified a significant mis-match in the number of patients that are currently waiting for treatment on the Trust waiting list and a sustainable waiting list size based on the demand coming through. The Trust has reported that is has had 4400 patients on the admitted waiting list and this number needs to be 2000 to reach a sustainable balance. The Trust also has 801 (189 undated as of 3/11/13) patients currently waiting over 18 weeks and a further 328 undated above 16 weeks.

2.0 Capacity Demand work

The Trust carried out some preliminary work in a number of key specialities[1] with technical support from the IST to understand the capacity required in these specialities to achieve a compliant pathway. This work has informed the both the internal capacity plan increase and the Trust draft trajectories for 18 weeks. For the majority of specialities, this showed a mis-match in capacity against demand.

1. General Surgery, Trauma Orthopaedics, OMFS, Ophthalmology, ENT.

3.0 Trust Capacity Increase (Internal)

The Trust has historically carried out waiting list initiatives and continues to carry them out during 2013/14. Mindful of the capacity demand work the Trust is currently working toward increasing the capacity which is outlined in Appendix 1. The work has focussed on increasing elective capacity at CMH and emergency capacity at NPH (not included in this paper).

4.0 Trajectory

The increase in capacity has been mapped which has identified that for the majority of specialities who are currently failing the admitted performance target of 90%, a return to performance will either take a significant length of time or performance is not due to return into positive balance. The trajectories show a remaining in-balance across a number of specialities after the Trust has delivered additional activity. See Appendix 2.

Work continues to confirm the accuracy of the trajectory which will be reforecast after 4 weeks in order to provide better assurance to the Commissioners that the figures reported are becoming more reliable and to assess the impact of the outsourcing volumes.

5.0 Meeting the Residual Gap

In order to improve the timescales to achieve a waiting list sizes by speciality that are closer to their sustainable waiting list targets the Trust and CCGs are agreeing a process for outsourcing patients. There are many different methods for delivery however this paper will focus on the agreement to outsource at two points:

1. 16 weeks and above undated
2. At the point of decision to treat and addition to the admitted patient waiting list.

6.0 Outsourcing Process

6.1 Patient Selection

The patient group will be selected from all specialities where there are RTT performance issues who have patients on the admitted waiting list. The following exclusion criteria should be applied:

- cancer
- tertiary
- complex
- revision surgery
- dated by the Trust
- urgent (patients requiring treatment within 4 weeks)

The Clinical Directors will be consulted on the patients that are currently undated across their specialities to ensure any specific procedures that are clinically contra-indicated for outsource remain with the Trust.

The patient will be initially selected as one off large group to take into account the start of the process with a priority on the longest waiting patients (patients waiting >16 weeks). This will begin on 20 November 2013. The process will then continue on a weekly basis pulling forward new patients added to the waiting list in the last week and those reaching 16 weeks without a date.

Patients sent from <12 weeks would expect to be treated before 18 weeks at the alternative provider.

6.2 Patient Tracking

Code change **-** Once selected the patients would be coded using the National guidelines code for provider to provider transfer. The Trust will have an "Outsource PTl" which will be reviewed weekly which will track the patients that have been identified as potential transfers. The patients will not show on the Trust's weekly PTL monitoring sheets, which will prevent any duplication of process in terms of appointments/booking. The Outsource PTL will identify this specific cohort of patients by using ICS free text boxes to identify them as well as the specific external providers used in the outsource process.

Letter to Patients **-** The Trust will send an agreed letter to the patients identified. This will explain the process and ask the patients to contact the Trust on a dedicated phone line if they wish to keep their treatment at the Trust. The letter will be a positive response letter, i.e. If patients do not respond back to the Trust, the Trust would treat this as consent to transfer to another provider. The letter will also contain information regarding the consent to transfer of the patient's information to another provider. The Trust will have a dedicated team to monitor the trackers and receive phone calls from patients. The letter is shown in Appendix 3 PDF file. Any patients wishing to remain with the Trust will have the code changed back to an internal code and will remain on the waiting list not disadvantaged by this process.

Provider to provider **-** The patient tracker list will be sent to the external provider weekly in agreed formats which will be the same for all external providers. This will be updated by the external providers twice a week providing the Trust with up to date information of appointments and admission dates. The provider will contact the patient for their appointments to receive their treatment. Any patients who wish to return to the Trust or need to return for valid clinical reasons

will be identified on the tracker and the code will be changed and the patient returned to the Trust waiting list, not disadvantaged by this process.

The Trust will send the minimum data set and agree with external providers on the relevant medical information required by the external providers. Where possible the Trust will copy the relevant patient medical records and send by secure fax/courier. In exceptional circumstances the Trust will send the original copy of the notes. Relevant diagnostics will be shared on the inter Trust image exchange portal or direct on CD or to a secure fax.

Access Policy – The Trust's Access Policy has been revised and as soon as this has been agreed with CCGs will be shared with the providers and they will be expected to follow the same process that would happen in the Trust. This would ensure that the principles that patients should be fit, willing and able to receive their treatment are adhered to.

Admission criteria – If the external provider clinician feels that the treatment choice decided on by the Trust Consultant is not in the patients best interest at the time of the consultation at the external provider the patient should be discharged to the GP with the appropriate management plan. Where there are clinical exceptions the external provider Clinician should seek to contact the NWLHT Consultant.

6.3 Reporting

In normal circumstances the National rules concerning provider to provider allows for the 18 week pathway to be handed over the receiving Trust and that Trust counts the admission and corresponding performance. In exceptional circumstances and with commissioner support providers can agree to "manually" adjust the performance statistics sent to UNIFY2 to reflect that the performance was of the original Trust.

This paper proposes that the NWLHT reports the performance stats of all the outsourced patients to other providers. The CCGs, CSU and the Trust would need to ensure that both NWLHT and the providers manually update the same information so that the performance is removed from the external provider and is shown in the NWLHT UNIFY2 dataset.

7.0 Outsourced inclusions

The outsourcing will include all elements of the patient pathway after decision to treat. This is not limited to but would include Out-patient (as appropriate) and pre-op attendances, Treatment, post-op follow up and any subsequent rehabilitation in the community if this is required. The contract will also include translation services, transport and any other associated support service required to treat the patient. The providers will ensure that any notes associated with the treatment are copied and returned to the Trust to insert back into the patient notes. Where patient's treatments are part of the PPWT or IFR process, the agreement for payment for these procedures is between the CCGs and other Providers involved in this process. The NWLHT will send the PPWT or IFR request to the NWLCSU team as normal.

8.0 Resources Required

The Trust will set up a dedicated area to manage this process. It will require the skills of senior staff internally from both information and the Access teams. The overall resource will be:

- 1 WTE Band 2 Medical records
- 1 WTE Band 3 Access Centre Support staff
- 1 WTE Band 3 Radiology records management.

This will be monitored and may need to increase as the complexity and numbers of providers increase.

The CCGs have agreed funding for a lead for this team to work within the Trust and a programme manager from the CSU to oversee the overall process, maximise appropriate uptake and take action as required, assuring the process and progress of the outsourcing scheme in delivering the anticipated benefits for patients and resultant reductions in waiting times.

9.0 Risks

A number of risks have been identified both to the success of this process and in the process itself. These have been identified in a table in Appendix 4 with the largest risk remaining with the volume of patients that are likely to be choose to be treated elsewhere, risk score 12. This was noticeable when the Trust last carried out this process in February 2012.

10.0 KPIs to be agreed with CSU

This section is to be finalised between the CCGs / CSU and providers.

The following key performance indicators have been identified to monitor progress:

Indicator	Target	Action for underperformance
Number of patients accepting another provider	70% (TBC)	CSU/NWLHT/Provider meeting. Review letters, review phone calls and tracker log for decline reasons. Action plans to mitigate
Number of patients once accepted receiving treatment	90% (TBC)	CSU/NWLHT/Provider meeting. Review tracker log. Action plans to mitigate.
Treatment within 4 weeks	60% (TBC)	CSU/Provider meeting
Treatment within 6 weeks	98% (TBC)	CSU / Provider meeting
Return time for referral back to Trust if clinically appropriate (max 2 weeks)	95% (TBC)	CSU / Provider/ NWLHT meeting. Exception report and action plan.

The CSU programme manager will monitor the KPI standards once agreed, raise underperformance with the providers, report back on requirements to NWLHT and to the CCGs and take forward actions to address shortfalls.

11.0 Conclusions

The Trust is increasing the overall capacity for theatres to manage both emergency and elective pathways. Overall the Trust is increasing the elective capacity by 87 theatre lists per month by the end of March 2014 however this will not meet demand across a number of specialities.

The outsourcing allows the Trust to reduce the overall size of the waiting lists across the specialities by utilising capacity at other centres. The Trust will report both the positive and negative performance results from this activity undertaken on its behalf.

There will be a positive reduction in the overall size of the waiting list which will depend on the success on the outsource process and the Trust will have maintained and maximised its existing theatre schedules through booking the volume of work not outsourced on the waiting list.

12.0 Recommendations

It is recommended that the out-sourcing process commences with the first list of patients on 20th November 2013.

It is recommended that the Trust 18-week steering group monitors progress and takes action within the Trust where required to ensure that it succeeds.

The overall scrutiny of the delivery and success of the programme will be maintained by the CCGs and the CSU.

Authors:

Sean McCloy, Head of Performance

NWLHT.

Liz McLean

Interim Account Director

CSU

14th November 2013.

Appendix 1 – Admitted Capacity Increase

October 21st 2013 **Location CMH.**	**Extra lists / 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
ENT	2	6	Capacity used by Gen Surgery and Urology up to end of November.
OMFS	3	9	Y
Ortho	8* * previously CEPOD and trauma	12	Y

Capacity to be delivered by Trust:

Plan start date 4th November 2013 **Location CMH**	**Extra lists / 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
Ophthalmology	8	32	Y
Plan start date 15th December 2013 **Location NPH**	**Extra lists / 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
Colorectal	4	10	N
Plan start date 31st January 2013 **Location CMH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
ENT	10	30	
OMFS	4	12	
Ortho	26	52	
Gen Surg	8	24	
Vasc	2	6	
Urology	4	12	
Plan start date 15th March 2014 **Location NPH**	**Extra lists/ 4 week month**	**Est. Increase in Patient per month**	**Achieved (Y/N)**
OMFS	4	12	

Gen Surg	4	12	

Planned Outsourcing volumes:

Provider Name	Total Volumes (@08.09.13)	RNTNE	Chelwest	THH	BMI
GENERAL SURGERY	402		60	141	201
UROLOGY	264			132	132
OMFS	475		190	190	95
COLORECTAL SURGERY	355		142	142	71
VASCULAR SURGERY	131			79	52
TRAUMA & ORTHOPAEDICS	879		293	293	293
ENT	866	736			130
OPHTHALMOLOGY	245			49	196
GYNAECOLOGY	544		218		326
Totals by Provider	4161	736	903	1025	1496
Overall percentage split	100%	17%	21%	24%	35%

Outsourced costs and average prices:

Based on avg waiting list for NWL hospital

Specialty	Activity	Cost
Colorectal Surgery	130	£370,496
ENT	348	£568,549
General Surgery	148	£235,894
Gynaecology	205	£270,360
Ophthalmology	30	£26,481
Orthodontics & Maxillo-Facial Surgery	166	
Trauma & Orthopaedics	368	£1,154,046
Urology	65	£68,350
Vascular Surgery	40	£71,922
Total	**1500**	**£2,766,098**

Based on best waiting list position across NWL hospital

Specialty	Activity	Cost
Colorectal Surgery	173	£493,995
ENT	465	£758,065
General Surgery	197	£314,525
Gynaecology	273	£360,479
Ophthalmology	40	£35,308
Orthodondics & Maxillo-Facial Surgery	222	
Trauma & Orthopaedics	490	£1,538,728
Urology	87	£91,134
Vascular Surgery	53	£95,896
Total	**2000**	**£3,688,131**

Appendix 2

Trajectories	Orthopaedics	General Surgery	Colorectal	OMFS	ENT	Ophthalmology	Gynaecology	Vascular	Urology
Current Core	1392	580	616	671	986	603	898	415	712
Regular excess	176	431	412	319	240	263	357	32	151
Proposed actions	150	85	18	57	68	42	18	0	5
Sub-total	1718	1096	1046	1047	1294	908	1273	447	868
W/L as at 8th Sept	879	402	355	475	866	245	544	131	264
additions - usual	1456	1031	1153	1152	1335	971	1335	455	1001
additions from OP backlog	22	74	67	78	194	90	0	29	51
Validations	53	24	0	48	75	0	12	15	18
Sub-total	2304	1483	1575	1657	2320	1306	1867	600	1298
w/l as at 31st Mar									
all above actions	586	387	529	610	1026	398	594	153	430
core only	912	903	959	986	1334	703	969	185	586
core & excess	736	472	547	667	1094	440	612	153	435
Sustainable target	285	163	145	206	303	196	213	67	159
Distance from sustainable target as at 31st March									
all above actions	301	224	384	404	723	202	381	86	271
core only	627	740	814	780	1031	507	756	118	427
core & excess	451	309	402	461	791	244	399	86	276
Date target met with current actions	***Aug-14***	***Dec-14***	***Does not***	***Does not***	***Jan-19***	***Jan-16***	***Does not***	***Dec-17***	***Does not***

Appendix 3

Letter to patients.

Patient letter template.pdf

Appendix 4

Risk	Likelihood	Consequence	Score	Mitigation	Residual
Small numbers of patients will take up opportunity to transfer.	4	4	16	Utilisation of same Consultant at BMI Provider staff telephoning, Greater awareness of patient rights.	12
Patients will complain that their data has been shared with another provider.	3	4	12	Letter to contain information on intent to data share. Patient has to communicate in order to retract this.	6
Patients information will be lost from the Trust waiting list therefore patient won't be contacted by either provider delaying their care.	2	4	8	Pathway supports staff data entry, only trained staff to use Trust ICS system. Senior staff to oversee process.	2
The Trust will lose visibility of the patients once they are transferred to another provider risking that a patient could fall in a gap of communication delaying their treatment.	2	4	8	There will be a separate patient tracking list for outsourced patients which will track patients moving forward. List will identify the specific cohorts in this group using freetext to uniquely identify them. The Trust will also have a tracker with external providers tracking updates on patients.	2

Brent	**Health Partnerships Overview and Scrutiny Committee** 4th December 2013 **Report from the Assistant Chief Executive**
For Action	Wards Affected: ALL

Update on Plans for Central Middlesex Hospital

1.0 Summary

1.1 In October the Secretary of State for Health gave his broad approval to the changes being made to hospitals in North West London known as "Shaping a Healthier Future". Brent CCG, in conjunction with the North West London Collaboration of CCGs, has been asked to provide an update on the plans for Central Middlesex Hospital which will now follow as a direct consequence of the Shaping a Healthier Future plans.

1.2 The report provides a short overview of:

- the four main workstreams;
- key options being considered;
- planned next steps.

The final recommendations will be reported for approval to the SaHF Partnership Board and Implementation Programme Board on 6th February.

2.0 Recommendations

2.1 The committee is recommended to question representatives of Brent CCG and the North West London Collaboration of CCGs on the planned proposals; including the closure schedule for the A&E, the range of services most likely to be provided and financial implications (including PFI arrangements and the plans for existing assets and property).

Contact Officers

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SaHF and Central Middlesex Hospital

Update for Brent Overview and Scrutiny Committee 4th December 2013

Shaping a healthier future – brief summary to date

- SaHF is a clinician led programme which set out to develop a vision for how we want health services to be developed and improved in NW London.
- Increasing care delivered closer to home will better coordinate services and improve quality. SaHF will save at least 130 lives per year.
- Local services will be co-designed by clinicians and local residents around the specific needs of the population.
- Staff will gain improved specialist knowledge specific to their role and services will be integrated across the system.
- A full public consultation ran from July to October 2012 where the team ran over 200 meetings, sent 73000 consultation documents and received 17,000 responses
- In February 2013 the Joint Committee of PCTs agreed the programme recommendations.
- The IRP report has now been endorsed in full by the Secretary of State for Health, with some refinements specific to Ealing and Charing Cross.

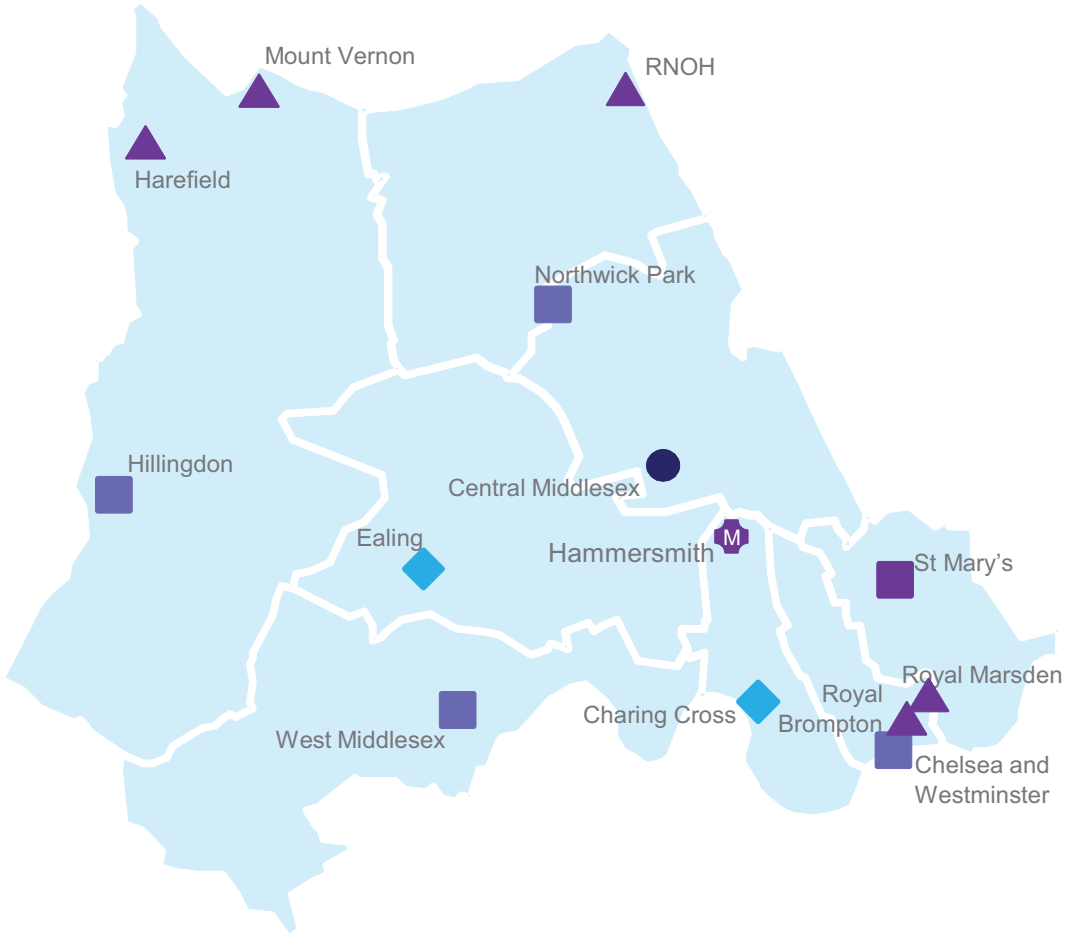
The decision by the Secretary of State for Health

- On Wednesday 30 October the Secretary of State for Health accepted advice from the IRP "in full" and agreed that changes to NHS services in North West London should proceed, including the move to five major hospitals.
- Secretary of State for Health said: *(All quotes from Jeremy Hunt's statement to the House of Commons unless otherwise stated)*
  - "These changes represent the most ambitious plans to transform care put forward by any NHS local area to date. They are forward-thinking and address many of the most pressing issues facing the NHS, including seven-day working, improved hospital safety and proactive out-of-hospital and GP services."
  - "The improvements in emergency care alone should save about 130 lives per annum and the transformation in out-of-hospital care many more, giving north-west London probably the best out-of-hospital care anywhere in the country."
  - "The panel says that "Shaping a healthier future" provides "the way forward for the future and that the proposals for change will enable the provision of safe, sustainable and accessible services." Today I have accepted the panel's advice in full and it will be published on the panel's website."
  - "Ealing and Charing Cross hospitals should continue to offer an A&E service, even if it is a different shape or size from that currently offered."
  - "Local services will be designed by clinicians and local residents and will be based on the specific needs of the population."

The decision by the Secretary of State for Health

- "Further work is required before a final decision can be made about the range of services to be provided from the Ealing and Charing Cross hospital sites."
- "Any changes implemented as part of *Shaping a healthier future* should be implemented by local commissioners following proper public engagement and in line with the emerging principles of the Keogh review of accident and emergency services."
- "In line with the emerging findings of Bruce Keogh's review of A&E, Charing Cross and Ealing hospitals must provide:
  -immediate access to specialist consultant opinion
  -a wide range of diagnostic services
  -the ability to admit people for assessment, treatment and rehabilitation"
- In line with the IRP report, "changes to A&E at **Central Middlesex** and Hammersmith hospitals should be implemented as soon as practicable".
- "I support the Panel's recommendation that maternity and paediatric inpatient services should be concentrated on the sites identified by *Shaping a healthier future*".

Hospitals post reconfiguration



- Specialist hospital
- Local and Specialist hospital with obstetric-led maternity unit and UCC
- Local and Elective hospital with UCC
- Local and Major hospital with A&E and UCC
- Local and Major hospital and specialist eye hospital and Hyper Acute Stroke Unit with A&E and UCC
- Local hospital with A&E

Shaping a healthier future

What does this mean for CMH?

- IRP and SoS confirmed as in SaHF proposals that CMH will be a **Local Hospital and Elective Centre.**
- This creates potential for significant investment in CMH site.
- Specifically : *"Changes to A&E services at Central Middlesex and Hammersmith hospitals should be made as soon as practicable after winter."*
- Work now being undertaken to build long term sustainable model for CMH site.
- Needs to consider clinical viability of a mix of services for the CMH site.
- Assessment of other key factors: travel, equalities, and timetable.

What does this mean for CMH?

- Key that we have full patient involvement in designing services at CMH.
- Engagement plan in development.
- This will include full consideration of any potential needs for further consultation if changes not included in SaHF require such consultation.
- Also – important to note that safety issues which have restricted the opening hours of the A&E at CMH are *not* related to SaHF – these are clinical safety issues which come first, over and above any long term re-organisation being planned.

Working groups on CMH

- Planning for this being done through four workstreams
- These workstreams are:

1. Clinical Evaluation – quality of care, deliverability, research and education (clinical panel with specialist expertise chaired by Mark Spencer, NHSE)
2. Estates and Finance Analysis - affordability and value for money (BDO)
3. Access to Care Analysis - access to care and impact of changed patient journeys as a result of movement of services from their current sites to CMH (PA Consulting)
4. Equalities Impact Assessment – analysis on protected patient groups will ensure any potential adverse and positive impacts are identified and mitigated where possible (led by SaHF Equalities Lead)

Options being considered (1/2)

- Transfer of mental heath services from adjacent Park Royal site
- Elective orthopaedic centre for NWLHT, Ealing and Imperial
- Relocation of clinical genetics – Kennedy Galton Centre – ideal for relocation as standalone regional site – NHSE Specialised Commissioning support
- Extended range of community based services (Hub+)
  - Primary Care
  - Diagnostics
  - Out-patient clinics
  - Relocation and expansion of community rehabilitation beds at Willesden – any impact on Willesden will be considered as part of options evaluation

Options being considered (2/2)

- Assessment (as a reference point to compare options against) will include:
  - PFI affordability analysis
  - Disposal with transfer of activity

Planned next steps

- Weekly meetings to ensure progress and delivery of the worksteams.
- Patient involvement proposals and plan being developed.
- Stakeholder workshop to be scheduled – with LA and patient representatives.
- Final report with recommendation will be approved through Partnership Board and Implementation Programme Board on 6th February 2014.
- Approval through decision making authorities: NTDA, CCGs, NHSE, Trusts.
- OBC development for investment in site, with patient and stakeholder involvement and input.

Questions

Health Partnerships OSC

Work Programme 2013-14

Meeting Date	Item	Issue
Dec 2013	Wave 2 Update	Update on the Impact Assessment and Consultation proposals for Wave 2 commissioning of musculoskeletal services, trauma and orthopaedics, rheumatology and gynaecology.
Dec 2013	Winter A&E Provision	Report on CCG and NWLHT's plans to ensure to deal with winter demand and to ensure that A&E is able to cope with this.
Dec 2013	Plans for Central Middlesex	Update on proposals for services at Central Middlesex Hospital under "Shaping a Healthier Future".
TBC	Mental Health services	Including services provided by: CNWL, CCG, Council Social Services.
TBC	Maternity Services	Maternity care in Brent, including proposed changes proposed under Shaping a Healthier Future
Recurring	Emergency Services	Current issues around emergency services/A&E at North West London Hospitals and immediate, mid and long term plans to address current problems and improve services.
Recurring	NWLHT and EHT Merger	Update on the merger between North West London Hospitals Trust and Ealing Hospitals Trust and on current progress against financial targets.
Dec/Jan	Current diabetes services and future commissioning	To establish what services are currently provided and what the future commissioning plans are by the organisations now charged with providing them.
TBC	Public Health	At the June 2013 HOSC members commented of the need to receive regular reports on how public health services were working.
TBC	Health Visitors	Following previous concerns about the recruitment and retention of Health Visitors, the committee
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	Palliative care	Following a presentation from the CCG followed by St Luke's Hospice in March 2013, the committed requested that the CCG return with a more detailed report on Palliative Care in Brent and that included the Brent End of Life Strategy which was not available to members at the time of the meeting.
TBC	Diabetes and	NHS Brent plans to re-commission diabetes and physiotherapy services in the borough. The committee

	physiotherapy services – plans to re-commission services in Brent	should consider the plans for the new services, as well as the consultation plan.
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	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	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.
	Teenage Pregnancy	Members have asked for a report on teenage pregnancy in Brent, the services available and conception rates amongst teenagers.
	Abortion services in Brent	Councillors have asked for a report on abortion services in Brent, and the abortion rates in the borough, including repeat abortions. This could include a more general update on sexual health provision in Brent.
TBC	Brent MENCAP Update on work	At the November 2012 HOSC members heard from MENCAP on their work around Health Services for People with Learning Disabilities. Members requested an update on MENCAPs work at a future meeting.
TBC	Diabetes Task Group	Update on progress of the Diabetes Task Group recommendations.

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