Independent Healthcare Commission for North West London

Submissions of Written Evidence

Volume 2

Contents:

London Borough of Hammersmith & Fulham
Councillor Andrew Brown
Town Ward
Conservative Spokesman for Health & Adult Social Care
Hammersmith Town Hall, King Street,
London W6 9JU
Tel: 020 8753 1011
Email: andrew.brown@lbhf.gov.uk

h&f
hammersmith & fulham

24th February 2015

Michael Mansfield QC
c/o Peter Smith
Hammersmith Town Hall
King Street
London
W6 9JU

Dear Mr Mansfield,

Response on behalf of the Conservative Group to the Independent Healthcare Commission

The Conservative Group welcomes any scrutiny of local NHS, social care, public health and other healthcare services. The challenges facing our local hospitals this winter shows that although staff work exceptionally hard, there is still more to be done to improve the systems across the healthcare sector to improve patient care. We believe that this commission if conducted in a proper, independent manner, can contribute to this scrutiny.

It is important for the commission to consider the verdicts of the two judicial reviews made by Ealing Council into the consultation process for Shaping a Healthier Future, as well as the Independent Reconfiguration Panel's findings, chaired by Lord Riberio, a former president of the Royal College of Surgeons. This commission should take into account the findings, both legal and clinical, that have preceded it.

One overarching principle that we believe in on health matters, is that the people making the decisions should be the experts. That isn't politicians or civil servants, but clinicians. Whilst we will continue to campaign for more and better services for the residents of LBHF in or near to the borough, we must ultimately accept clinician's opinions on what will improve care and the evidence that supports their views.

To this effect, we have included with our submission the following evidence, which we hope has already been considered, but have included in case it has not:

1. Letter of support in the Shaping a Healthier Future Proposal from Chairs of North West London CCGs
2. Letter of support in the Shaping a Healthier Future Proposal from Medical Directors of North West London Hospitals
3. High Quality Care for All - NHS Next Stage Review Final Report, June 2008 – This document started the process of hospital reconfiguration driven by then Labour Health Minister Professor Lord Darzi. In his Summary Letter he states: "We need to continue the NHS journey of improvements and move from an NHS that has rightly

focused on increasing the quantity of care to one that focuses on improving the quality of care." He then goes on to say "The acute care groups gave compelling arguments for saving lives by creating specialised centres for major trauma, heart attack and stroke care, supported by skilled ambulance services."

4. Acute and emergency care: prescribing the remedy. A join document from the College of Emergency Medicine, the Royal College of Physicians, the Royal College of Paediatrics and Child Health, and the Royal College of Surgeons, July 2014.
5. Seven Day Consultant Present Care. Academy of Medical Royal Colleges, December 2012.

Politics will always have some place in healthcare, because it is so important to people's lives and their families. However, the "weaponising" of healthcare issues for political reasons, is something that healthcare professionals and the public find deeply distasteful. It also severely damages healthcare debate which is a serious problem if we want an NHS that is strong and viable and can continue to provide world class care into the future. Weaponising the NHS has been criticised by leading Labour politicians and former secretaries of state for health such as Alan Milburn and former Labour health ministers such as Lord Darzi.

Worryingly we have received reports from local doctors and NHS professionals, that because of the behaviour of the leadership of this borough, the working relationships are not in a good state. It is one thing to scrutinise NHS bodies. It is another to behave in a dishonest, bullying, manipulative and unprofessional manner towards public servants and clinicians whose entire professional careers have been focused on improving people's health and saving their lives.

At the same time, the Labour Administration of LBHF is failing to tackle some of the key issues which are contributing to increased pressure and demand on acute hospital services, especially A&E. These include areas of public health, including vaccination campaigns, areas of social care which the new administration has cut annual funding for by £6.5 Million, as well as failures in properly promoting healthcare messages such as 7 day access to GPs at practices across the borough. If it hadn't been for the scrutiny of the Conservative Group, the administration's actions in some of these areas would have been even less.

What is even more concerning for the residents of this borough, especially those who depend on care, is that the future budget for adult social care is dependent on cross working with the local NHS to improve outcomes and increase prevention. The local NHS is in fact providing £2 Million of funding in the next financial year through the Better Care Fund, which was negotiated by the former administration. This investment will only achieve the outcomes that this borough so desperately needs if the council works well with the local NHS.

If the Labour administration is so steadfastly against any of the changes proposed in Shaping a Healthier Future, then should it not return the money for the Better Care Fund and ask the NHS to reinvest the £2 Million per annum in acute medical care, including A&Es?

Moving on to some of the specific questions raised in commission brief:

Closure of A&Es at Hammersmith and Central Middlesex Hospitals

As Hammersmith Hospital is in this borough, and is something that the LBHF Health committees have heard more about, I will focus comments primarily on that hospital.

The reasons behind the closures to the Hammersmith Hospital A&E were based on it being unable to provide a safe service to its users. As we have heard at multiple committee meetings, for a period of over a decade, due to the A&Es changing use, and the Hammersmith's continuing specialisation as a centre for emergency cardiac and renal care, it has no longer been possible to staff the A&E with Emergency Medicine Consultants. Instead it has been staffed by locum doctors. This has meant that the unit was unable to be used to train junior doctors in emergency medicine. This resulted in junior staff also being locums. Using locums means there is no continuity in the staff at the emergency unit, resulting in a reduction of quality care and safety for patients. This is something that we believe to have been an unacceptable situation for residents of LBHF, especially considering that many of those who used the Hammersmith A&E were from some of the most deprived parts of our borough.

Therefore the decision to close the Hammersmith A&E, which was supported and asked to be brought forward by the Independent Reconfiguration Panel, looks like the safe decision from a clinical perspective.

Since its closure however, combined with increased winter pressures and demand on all A&Es which has been seen across the UK, most of our local A&Es have seen increases in waiting times, which are well below the national targets. Whilst the increased cases of influenza due to mutation of the strain primarily targeted by the vaccine is some mitigation, A&E target results are frankly unacceptable. The exception to this is Chelsea and Westminster Hospital NHS Foundation Trust. Their performance with regard to waiting times should be applauded and learned from by other trusts.

Prior to the two A&E closures we were talked through extensive plans by the acute trusts, CCGs and London ambulance service, and we were assured that there would not be any reduction in the quality of service. In fact we were told that the quality of the services would improve, due to the ability to be able to recruit additional Emergency Medicine Consultants who would be able to extend the hours that consultants were present in A&E at both Charing Cross and St Mary's.

These plans however have clearly not been sufficient to address the added demand caused both by winter pressure and the closure of the A&Es. Imperial College Hospitals NHS Trusts, apologised for this at the health committee meeting in January and explained their plans to improve services. Whilst we welcome their apology and plans, we believe that more should have been done to prevent the significant deterioration in waiting times that has been seen. In particular the recruitment of additional Emergency Medicine Consultants should have been accelerated.

In particular the delayed completion of the new A&E facility at Northwick Park Hospital has clearly added to the pressures on all local hospitals at a particularly difficult time. This is an

extremely serious failing, which must be learnt from and not repeated. If penalty clauses were not included in the construction contracts for that building work, that is extremely regrettable, and it should be ensured that any time sensitive projects in the future have that and other safeguards in place to make sure patients' care is not compromised.

Loss of Acute Care Beds

Whilst the number of beds in the proposals for Charing Cross is significantly more than what was originally proposed, it is still a lot less than the current hospital. At a time of great change and uncertainty over hospital reorganisations, and at time when there is a very great pressure on acute hospital services, this is very worrying for many people.

We must accept that hospital care and medical knowledge has changed almost beyond recognition from when Charing Cross Hospital was built. The length of stays for many procedures have been slashed, with many more procedures now carried out as day cases. There is also a lot more care carried out in the community and that is an ongoing aspect of the Shaping a Healthier Future plans, and is being funded through the Better Care Fund.

However, as we have seen, with the closure of the two A&Es, plans often do not materialise as envisaged. As the proposals for the capital investment across North West London run up to 2020 and beyond, it seems sensible to add more flexibility to the number of beds proposed at the Charing Cross site. These could be used for elective care and procedures, or if demand for beds does fall because of investment in out of hospital services, then it could be converted into other use such as outpatient departments, or used as an intermediate care facility commissioned by the council to help patients rehabilitate following a medical emergency or procedure and help them safely transition and return to their home. This idea is something proposed by the former Conservative administration, that we would like to see continue to be explored.

Change to Charing Cross Site

The wording in the briefing for this commission was pejorative. The statement "demolish the current Charing Cross Hospital and replace it with a smaller building a fraction of the size" is misleading and adds to many people's concern. The proposals are in fact for a £150-£200 million new hospital to be built on the site, before the current hospital building is demolished. That is the right way to do things and will prevent problems such as what we have seen at Northwick Park.

It is of course true that the proposed new hospital will be smaller than the existing building, however what is now proposed is a lot larger than the first proposals, which the former Conservative council and the local community Save our Hospitals group campaign strongly against. The new cabinet member for Health, Cllr Lukey, recently conceded that the Conservative administration had negotiated a better deal than was originally proposed. She also added that we shouldn't have settled for that deal, which was inaccurate. We were continuing to campaign, and still campaign for additional services at Charing Cross, where it

is appropriate and clinically safe to do so. A good example would be for the elective surgery centre to be located at Charing Cross. Where we differed from the local Labour Party and admittedly, and regrettably, from the Save our Hospitals campaign was that we felt that the revised proposal for Charing Cross was a much better starting point from which to campaign for more. By supporting that proposal it at least ensured that there would be a truly recognisable hospital on the Charing Cross site.

We welcome the £150 Million proposed investment in the Charing Cross site, which will likely be a lot more when all the facilities are finally agreed. This investment is important because of the nature of the Charing Cross site. It has been known for years that the main building has significant structural and maintenance issues, which has contributed to services being moved away from Charing Cross over the last decade or more. A new hospital building would secure Charing Cross for generations, and remove the looming threat of closure that has afflicted it for many years.

We accept that the new hospital will be smaller than the existing building, for reasons we have stated above, but we must recognise that some of the current hospital is currently mothballed, and that a significant proportion of the main building is academic facilities for Imperial College Faculty of Medicine and not used by the NHS. With the additional medical school buildings, the surface car parking, Charing Cross Sports Club not to mention the residential towers and other buildings, there is a significant amount of the site that isn't used by the NHS.

Again, as we have stated above, we would like to see flexibility for more beds and outpatient clinics to be worked into the proposals, to allow assurance that if out of hospital targets are not met there is flexibility in the system to meet patients' needs. We would also like to see community facilities such as intermediate care beds run by the council or in partnership with Age UK or another third sector provider. It is crucial that the medical school, such an important part of the character of the area is accommodated and provided with new, improved facilities that will help Imperial College to continue to train some of the country's best doctors.

There is of course a reality that to help fund the new hospital building there will have to be housing on parts of the site, however that does not have to be tower blocks of flats. We would like to see other options explored, when it comes to the time that the proposals for the site are taken to the next stage.

Future of Charing Cross Hospital's A&E

It has been a very great point of contention about whether or not the future emergency unit at the proposed Charing Cross would have a recognisable A&E or not. We were promised by the NHS that it would be, and our continued support for their current proposal is dependent on that. As Cllr Lukey recently conceded, the proposal for the A&E at Charing Cross is for it to be consultant led, not GP led as has been claimed for months. In fact the A&Es at both Charing Cross and St Mary's are recruiting extra Emergency Medicine Consultants.

Is it not ironic that the Labour administration complain about the closure of the Hammersmith A&E, which hasn't had Emergency Medicine Consultants for years, and if categorised now would not be categorised as an A&E, nor even be allowed to open as it would be unsafe.

There is a significant complicating factor to any local discussion over the future of accident and emergency, especially considering that these proposals are for up to five years into the future or more. That complicating factor is the Keogh Review into Emergency Medicine, which is adding uncertainty into these proposals.

We call on the local NHS to guarantee that a future A&E (whether it is called an A&E, Emergency Unit, or something else) at the Charing Cross site, is recognisable as what is currently considered to be an A&E, has consultant leadership and coverage as good or better than is currently the case, and continues to admit ambulances where appropriate and safe to do so. It is of course right and proper, that, as now, patients with heart attacks or major trauma are triaged to the specialist centre that will provide them with the best care, clinical expertise and outcome.

Role of the Council

Since the Health and Social Care Act 2012 became law, the council's responsibilities with regards to public health, and integration of health and social care are much greater. That will be increased again when the Care Act comes into effect. The council has an obligation to do what it can to help reduce pressure on our NHS, especially the acute services such as A&E.

We call on the council to play a much greater role, which it has the authority, budget and ability to do, in the following areas:

1. Improving public health campaigns through campaigns to increase uptake of vaccination programmes, detection of chronic diseases, lifestyle change and others, making best use of public health evidence and expertise.
2. Help the NHS communicate health messages such as where to attend for different health conditions, 7 day access to some GP surgeries across the borough.
3. Help the NHS to ensure that as large a percentage of possible of residents are registered with a GP, and are not therefore using A&E as an alternative to primary care.
4. Invest in public health and not cut £346,000 next year from the public health budget, and instead invest the money in programmes to reduce pressure on A&Es.
5. Reduce the £6.5 million cut from the adult social care budget and instead find other ways to protect the social care budget.

Conclusion

We wish to reiterate that as long as the commission is conducted in a proper manner, and is not affected by political interference, it can add to the scrutiny and debate over the future of

healthcare provision in North West London. As the elected opposition in LBHF we would welcome the opportunity to give evidence in person.

Shaping a healthier future

NHS

North West London Collaboration of Clinical Commissioning Groups

15 Marylebone Road
London NW1 5JD

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SWIA 2N8.

17th October 2013

Dear Mr Hunt

IRP review into NW London 'Shaping a Healthier Future'

We understand from the comments that Jane Ellison, Parliamentary Under-Secretary of State for Health made at the Westminster Hall debate 15 October that your decision on the Independent Reconfiguration Panel review will be imminent. On behalf of all the GPs on our 8 Governing bodies we wanted to re-iterate our support for the recommendations that the Joint Committee of the PCTs made on 19th February. We hope that the following points will be helpful in you making final decisions on the IRP recommendations:

- We remain absolutely confident that delivering the Shaping a Healthier Future recommendations in full will save many lives each year and significantly improve patient's care and experience of the NHS. We have spent 3 years developing these proposals.. Our strategy meets all the challenges set out in the case for change and an unambiguous decision from you will enable us to seize this opportunity to create a clear and comprehensive plan for the future and end the uncertainty which can obstruct clinicians in delivering care to the highest standards. It would be a tragedy if we lost this once in a life time opportunity.

- We felt that the IRP conducted a thorough and detailed review of the SaHF programme. Lord Ribero and his team robustly explored with us our clinical commitment to the proposals and our leadership of its implementation. We are confident they will present an accurate picture of the very high level of clinical support for this programme across NW London.

- Since February we have continued to build on the clinical commitment to change that has been unleashed. We believe that we have submitted a powerful application for the whole of NW London to become one of Norman Lamb's **Whole System Integrated Care Pioneers**. We had the launch event for our programme on 3rd October where medical and managerial leadership of all 29 organisations taking part in bid made a collective powerful case for why integrated care was the right thing to do for the people of NW London. We can only deliver the integration that we aspire to if we simultaneously make the changes that we have proposed for hospitals.

- This week we submitted an application to Sir Bruce Keogh to be an **early adopter of the 7 day working** principles. Based on the work we have done for SaHF we believe that can quickly deliver significant improvements in 7 day working in hospitals and also and importantly in primary care. We have already set up in one of the CCG's practices open all day every Saturday and Sunday.

- We are pleased that Mr Judge Mitting found last Thursday, that we had conducted a robust and fair consultation, that we had taken account of the needs of the population of Ealing and that we had complied with our statutory equality duties. This removed the last legal hurdle to implement these changes.

We are confident that the Shaping a Healthier Future programme is in the best interests of the two million people who live in NW London. As the clinical leaders of the NW London health and care community we are determined lead its implementation and do this in partnership with the Medical Directors of all the providers.

If you felt it would be helpful we would be pleased to meet with you to explain why we are so committed to this programme. We very much hope that you will feel able to support the recommendations that the IRP have made in full and to make this known at the earliest possible opportunity.

Yours sincerely,

Dr Ruth O'Hare
Chair, Central London CCG

Dr Fiona Butler
Chair, West London CCG

Dr Tim Spicer
Chair, Hammersmith & Fulham CCG

Dr Nicola Burbidge
Chair, Hounslow CCG

Dr Mohini Parmar
Chair, Ealing CCG

Dr Ethie Kong
Chair, Brent CCG

Dr Amol Kelshiker
Chair, Harrow CCG

Dr Ian Goodman
Chair, Hillingdon CCG

Cc Sir Bruce Keogh – Medical Director NHS England
Rob Larkman – Chief Officer Brent, Ealing Harrow, Hillingdon CCGs
Daniel Elkeles – Chief Officer, Central London, West London, Hammersmith & Fulham and Hounslow CCGs

Central and North West London NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ealing Hospital NHS
NHS Trust

Imperial College Healthcare NHS
NHS Trust

The Hillingdon Hospitals NHS
NHS Foundation Trust

Royal Brompton & Harefield NHS
NHS Foundation Trust

The ROYAL MARSDEN
NHS Foundation Trust

West London Mental Health NHS
NHS Trust

West Middlesex University Hospital NHS
NHS Trust

15 Marylebone Road
London NW1 5JD

22 October 2013

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SWIA 2N8.

Dear Mr Hunt

Re. Shaping a Healthier Future

We are writing as the Medical Directors of all of the Acute and Mental Health Trusts in North West London.

We have previously written in February to affirm our commitment to the proposals that were to be considered by the Joint Committee of PCTs (JCPCT) in February 2013 and now want to reaffirm our agreement with the decision made by the JCPCT and our commitment to implementing this proposal in partnership with the GPs in the local CCGs.

We have carefully studied the evidence to confirm that moving to fewer acute sites will allow improved care by having consistent larger consultant delivered services. We were intimately involved in agreeing the model of care with five major hospitals across the region.

We recognise that some local people feel anxious about the changes but are certain that these changes will save lives, whereas delays will leave fragile services that expose patients to unnecessary risks. We know that providing seven day services will save lives and improve patients care and satisfaction.

We agree also that these necessary hospital changes need to be implemented alongside investment and improvements in General Practice, Community Nursing and Social Care Support Services as enabled by this programme.

Many of us have had the opportunity to express our views to the Independent Review Panel and we look forward to their carefully considered report.

We are clear that these changes need implementing as soon as it is safe to do so; Indeed delays expose patients to serious risk and several of the current services are clinically and financially unsustainable. We urge you to support their findings which we know will benefit our populations care.

Yours sincerely

Dr Stella Barnass
Medical Director, West Middlesex University Hospital NHS Trust

Dr Nick Broughton
Med Director, West London Mental Health NHS Trust

Prof Nick Cheshire
Med Director, Imperial College Healthcare NHS Trust

Prof Tim Evans
Medical Director, Royal Brompton and Harefield NHS FT

Prof Martin Gore
Medical Director, The Royal Marsden NHS FT

Dr Abbas Khakoo, Joint Medical Director
The Hillingdon Hospitals NHS FT

Dr Richard Grocott-Mason, Joint Medical Director
The Hillingdon Hospitals NHS FT

Dr Alex Lewis
Medical Director, Central North West London NHS FT

Miss Zoe Penn
Medical Director, Chelsea and Westminster NHS FT

Dr Alfa Sa'adu
Medical Director, Ealing Hospital NHS Trust

Cc Sir Bruce Keogh – Medical Director NHS England
Sir David Nicholson – Chief Executive NHS England
Dr Anne Rainsberry – Chief Executive NHS England (London)
Dr Mohini Parmar – Chair Ealing CCG
Dr Ian Goodman – Chair Hillingdon CCG
Dr Nicola Burbidge - Chair Hounslow CCG
Dr Ethie Kong – Chair Brent CCG
Dr Amol Kelshiker – Chair Harrow CCG
Dr Fiona Butler – Chair West London CCG
Dr Ruth O Hare – Chair Central London CCG
Dr Tim Spicer – Chair Hammersmith and Fulham CCG

Royal College of Physicians | The College of Emergency Medicine | RCPCH Royal College of Paediatrics and Child Health Leading the way in Children's Health | RCS Advancing Surgical Standards

Acute and emergency care: prescribing the remedy

Urgent and emergency care services face profound pressures that are most obviously experienced by patients and clinicians working in emergency departments and acute admission wards. This policy paper sets out 13 recommendations to address these challenges and to build safer, more effective and efficient urgent and emergency care services for all patients.

The College of Emergency Medicine is committed to ensuring that emergency care in the UK and Ireland is delivered to a high standard in a system that is safe for patients and sustainable for clinicians. The recommendations of this key summit are clear, concise and constructive. No plans for emergency care should be developed without consideration of these consensus recommendations.

Clifford Mann

Dr Clifford Mann, President
The College of Emergency Medicine

The recommendations set out in this report were informed by discussions that took place at a round-table event in spring 2014. The event, co-organised by the College of Emergency Medicine, the Royal College of Physicians, the Royal College of Surgeons, the Royal College of Paediatrics and Child Health and the NHS Confederation, brought together key policymakers, opinion-formers and leaders in acute healthcare to review how greater resilience can be built into urgent and emergency care services.

Whilst the emergency department may be the primary focus of public attention for urgent care, it represents only part of the urgent and emergency care system. Acute hospital services, general practice, mental health services, and community and social care are the other core components of the system. This policy paper identifies the key recommendations across all the components of urgent and emergency care that must be addressed if we are to avoid an annual crisis response and build a resilient system that is fit for purpose.

Challenges for urgent and emergency care

Currently the challenges faced by urgent and emergency services overwhelm the capacity of the system. In consequence the delivery of quality care is compromised. Key contributors to this phenomenon are rising acuity levels and a lack of accessible and effective alternatives to the emergency department. Further barriers include:

- complex discharge requirements and community integration
- emergency department crowding and patient flow into the hospital
- staff recruitment and retention in acute care specialties
- recognising and meeting the needs of specific patient groups, including frail older people, individuals with mental health conditions, homeless people, adolescents, infants, drug and alcohol users, and patients entering a final illness.

Building system resilience

Emergency care must be delivered 24 hours a day, 7 days a week, 365 days a year for all patients in need. System pressures can occur at any time and the system must be robust enough to withstand such pressures without compromising the delivery of care. The following recommendations must be implemented to ensure a resilient system that is fit for purpose.

For each recommendation, the main drivers are highlighted according to whether they operate at local or national level. Although a degree of shared responsibility invariably exists, this must not be a barrier to action or an excuse for delay.

This report is accompanied by a recommendations statement specifically referenced to the health and social care systems of England, Northern Ireland, Scotland and Wales.

Key:

L Local recommendations

N National recommendations

Access and alternatives

1 L Every emergency department should have a co-located primary care out-of-hours facility.

The entire urgent care needs of the population cannot be delivered within the same framework and resources as emergency care. It is not appropriate for accident and emergency to be regarded as 'anything and everything' or for the emergency department to be 'everyone's default'.[1]

It is unreasonable to expect patients to determine whether their symptoms reflect serious illness or more minor conditions. Co-location enables patients to be streamed following a triage assessment. This also enables collaborative working including sharing of diagnostic facilities, reduces duplication of administrative tasks and permits patients to be easily re-triaged should further assessment require so.[2]

2 N Best practice that directs patients to the right care, first time, should be promoted across the NHS so as to minimise repetition of assessment, delays to care and unnecessary duplication of effort.[3–5]

Examples of best practice include:

- stroke patients being transferred directly to stroke units
- medical patients who have been assessed by a GP being taken directly to the medical admissions unit
- elderly patients with multiple comorbidities undergoing investigation by multidisciplinary teams, not necessarily within the setting of the emergency department
- patients with post-operative complications being returned to surgical services
- patients suffering from falls being assessed first by ambulance falls services
- GP-to-consultant advice lines
- easy access to urgent clinics.

Such best practice must be complemented by agreed and implemented guidelines for the management of patients on acute medical and surgical units, mindful of the need for many such patients to receive cross-specialty care.

Skill mix / case mix

3 N All trainee doctors on acute specialty programmes should rotate though the emergency department.

In line with recommendations made in Shape of Training, Medical Royal Colleges should promote the development of core common competencies by all doctors in training.[6] Emergency department experience is an invaluable asset.[6] This will create a medical workforce with the interspecialty skills necessary to meet the clinical challenges of the future.

4 L Senior decision-makers at the front door of the hospital, and in surgical, medical or paediatric assessment units, should be normal practice, not the exception.

This is the most reliable way to deliver safe, effective and efficient care.[7,8] It should include acute physicians, acute paediatricians, GPs, emergency care physicians, geriatricians and psychiatrists. Early senior review has substantial proven benefits, including mortality reduction, lower admission rates, early safe discharge, reduced lengths of stay and more appropriate use of investigations.

5 N Emergency departments should have the appropriate skill mix and workforce to deliver safe, effective and efficient care.

Where an emergency department does not have on-site back-up from particular specialties, there should be robust networks of care and emergency referral pathways. NHS provider organisations should implement the recommendations of the Berwick report.[9]

6 L At times of peak activity, the system must have the capacity to deploy or make use of extra senior staff.[10]

If escalation procedures are a frequent occurrence, for example weekly, this is evidence of poor staffing models. Inadequate capacity exacerbates exit block and this in turn increases mortality for all patients.

Integration and communities

7 N Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services.[3,11,12]

This requires investment in the infrastructure of community care and a change in culture to remove many of the current procedural obstacles. The aim should be to facilitate the safe discharge and timely transfer of care of patients from the hospital to their own home or usual place of residence. This requires direct daily communication between the hospital and social care services, and integrated care planned in advance.

Delivering care to the homeless and to patients with alcohol and substance abuse problems are exemplar projects in which best practice models have delivered proven benefits.

8 L Community teams should be physically co-located with the emergency department to bridge the gap between the hospital and primary and social care, and to support vulnerable patients.

Co-located teams should include primary care practitioners, social workers and mental health professionals. The physical, mental and social needs of adults and children with acute or long-term mental health conditions are better met when psychiatric liaison services are easily accessible to staff working in the emergency department and acute medical units.[13] Best practice models for psychiatric liaison services should be adopted across the NHS.

Delivering care to the homeless and to patients with alcohol and substance abuse problems are exemplar projects in which best practice models have delivered proven benefits.

All emergency departments must have timely access to a paediatrician with safeguarding skills and experience.[14]

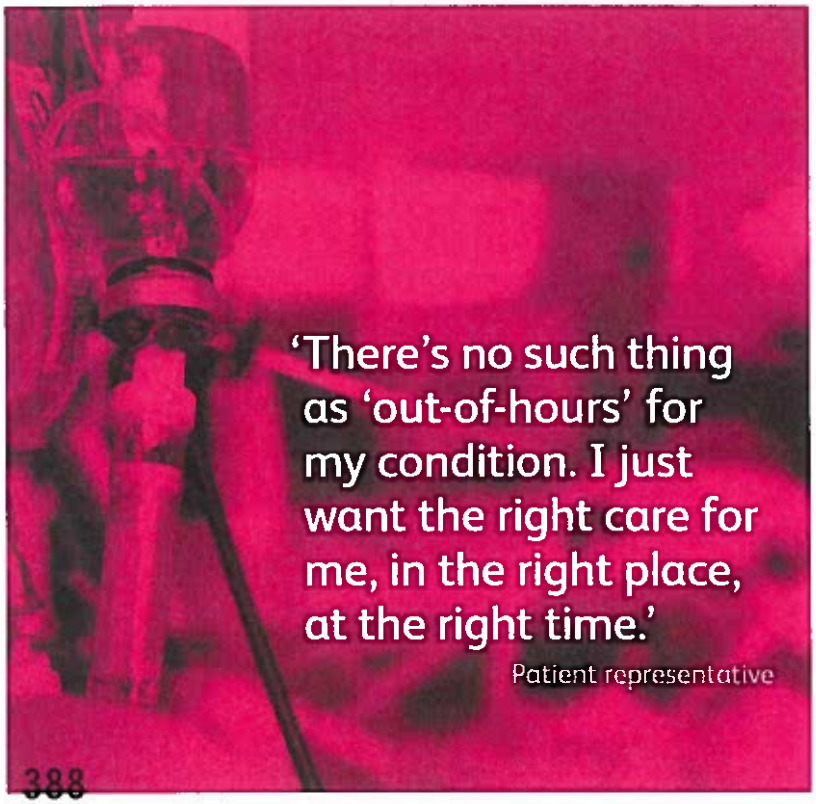
Seven-day service

9 N The delivery of a seven-day service in the NHS must ensure that emergency medicine services are delivered 24/7, with senior decision makers and full diagnostic support available 24 hours a day, including appropriate access to specialist services.[11] This will require additional resources.

This will enable equity of outcomes for all patients. Nevertheless, this will require sustainable staff rotas that encourage recruitment and retention.[15] Urgent and emergency care services must also develop and implement credible plans to meet predictable surges in demand, such as on bank holidays and when GP services close. If implemented properly, seven-day services can empower hospitals to return patients home sooner, reduce crowding and improve efficiency.

Health services are judged on two key components: the ability to deliver elective care and the ability to deliver urgent and emergency care. Neither should compromise the other.

Urgent and emergency care services must also develop and implement credible plans to meet predictable surges in demand, such as on bank holidays and when GP services close.



Funding / fair reward

10 N The funding and targets systems for emergency department attendances and acute admissions are unfit for purpose and require urgent change.

Funding structures currently penalise all acute care services and ensure that they are a loss-making activity for hospitals.[1] This condemns the system to be reactive, owing to a poverty of resources. Proactive behaviours are the hallmark of properly managed and sustainable systems. Though the 4 hour target is useful, it has insufficient drivers in place to eliminate exit block and has perverse effects. Targets must be aligned to support clinically relevant outcomes and the system reconfigured to better share ownership of risk and reward, thereby encouraging collaboration and innovation.

11 N Delivering 24/7 services requires new contractual arrangements that enable an equitable work–life balance.

Fairness and sustainability should underpin all staff contracts. Current contracts lack the mechanisms necessary to ensure that acute care specialists have a fair work–life balance. This issue has been recognised by the Secretary of State, the Department of Health, the NHS Confederation and the British Medical Association.[16–18]

If locum doctors are required to ease workforce shortages, then such locums should be rewarded with longer fixed-term contracts.

Training time is essential for equipping the medical workforce with the skills to handle system pressures. Trusts must also support staff suffering from 'burnout' due to current pressures.

Key:

L Local recommendations
N National recommendations

Information technology (IT)

12 L It is essential that each emergency department and acute admissions unit has an IT infrastructure that effectively integrates clinical and safeguarding information across all parts of the urgent and emergency care system.

Proper use of data can allow hospitals and acute care systems to predict with reasonable accuracy times of peak pressures using a calendar and system dashboards. This should inform capacity planning for medical staffing, bed planning, transport and diagnostics. The workforce should be able to access medical and safeguarding records promptly to ensure safe and efficient care. The IT infrastructure must also allow rapid notification of urgent and emergency care services to GPs, social care and children's services.

Current data are often of poor quality and certainly cannot be used with confidence to provide an accurate reflection of urgent and emergency care throughout the UK.

Proper use of data can allow hospitals and acute care systems to predict with reasonable accuracy times of peak pressures using a calendar and system dashboards.

13 N If configured properly with significant clinical involvement and advice, NHS 111, NHS 24, NHS Direct and equivalent telephone advice services can help to reduce the pressures on the urgent and emergency care system.

Telehealth staff should be able to access the medical records of patients, such as those found in the summary care record, and should be supplied with an electronic directory of all healthcare services. They should be able, with senior clinical support, to make appointments with primary care teams in cases where such a course of action is most clinically appropriate.

References

1 College of Emergency Medicine. 2013. 10 priorities for emergency medicine. http://secure.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/10%20priorities%20for%20Emergency%20Medicine [Accessed 30 May 2014].

2 NHS England. 2013. The Keogh Urgent and Emergency Care Review – end of stage 1 engagement report. www.nhs.uk/NHSEngland/keogh-review/Documents/UECR.Ph1Report.FV.pdf [Accessed 30 May 2014].

3 Royal College of Physicians. 2013. Future hospital case studies. www.rcplondon.ac.uk/projects/future-hospital-case-studies [Accessed 30 May 2014].

4 Royal College of Surgeons. 2011. Emergency surgery. Standards for unscheduled surgical care: guidance for providers, commissioners and service planners. www.rcseng.ac.uk/publications/docs/emergency-surgery-standards-for-unscheduled-care [Accessed 30 May 2014].

5 British Genatrics Society. 2010. Acute medical care of elderly people. www.bgs.org.uk/index.php/topresources/publicationfind/goodpractice/44-gpgacutecare [Accessed 30 May 2014].

6 Shape of Training. 2013. Securing the future of excellent patient care: final report of the independent review. www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf [Accessed 30 May 2014].

7 Academy of Medical Royal Colleges. 2012. The benefits of consultant-delivered care. www.aomrc.org.uk/general-news/benefits-of-consultant-delivered-care.html [Accessed 30 May 2014].

8 College of Emergency Medicine. 2010. Emergency medicine consultants workforce recommendations. http://secure.collemergencymed.ac.uk/code/document.asp?ID=5324 [Accessed 30 May 2014].

9 National Advisory Group on the Safety of Patients in England. 2013. A promise to learn – a commitment to act: improving the safety of patients in England. www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf [Accessed 30 May 2014].

10 College of Emergency Medicine. 2012. Crowding in emergency departments. http://secure.collemergencymed.ac.uk/code/document.asp?ID=6296 [Accessed 30 May 2014].

11 Academy of Medical Royal Colleges. 2012. Seven day consultant present care. www.aomrc.org.uk/doc_view/9532-seven-day-consultant-present-care [Accessed 30 May 2014]

12 House of Commons Health Committee. 2013. Urgent and emergency services: second report of session 2013–14. www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/171/171.pdf [Accessed 30 May 2014].

13 Royal College of Psychiatrists. 2013. Liaison psychiatry for every acute hospital: integrated mental and physical healthcare. www.rcpsych.ac.uk/files/pdfversion/CR183.pdf [Accessed 30 May 2014].

14 Royal College of Paediatrics and Child Health. 2014 Safeguarding children and young people: roles and competences for health care staff Third Edition. http://www.rcpch.ac.uk/system/files/protected/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3).pdf

15 College of Emergency Medicine. 2013. The advantages of a flexible, annualised rota for senior emergency medicine doctors. www.collemergencymed.ac.uk/code/document.asp?ID=7438 [Accessed 30 May 2014].

16 House of Commons, 26 November 2013: Column 139. www.publications.parliament.uk/pa/cm201314/cmhansrd/cm131126/debtext/131126-0001.htm [Accessed 30 May 2014].

17 NHS Confederation. 2013. Emergency care: an accident waiting to happen? www.nhsconfed.org/resources/2013/09/emergency-care-an-accident-waiting-to-happen [Accessed 30 May 2014].

18 Gretton A. Temporary staffing costs at region's busiest A&E quadruple. *Eastern Daily Press*, 22 April 2014. www.edp24.co.uk/news/health/temporary_staffing_costs_at_region_s_busiest_a_e_quadruple_1_3566904 [Accessed 30 May 2014].

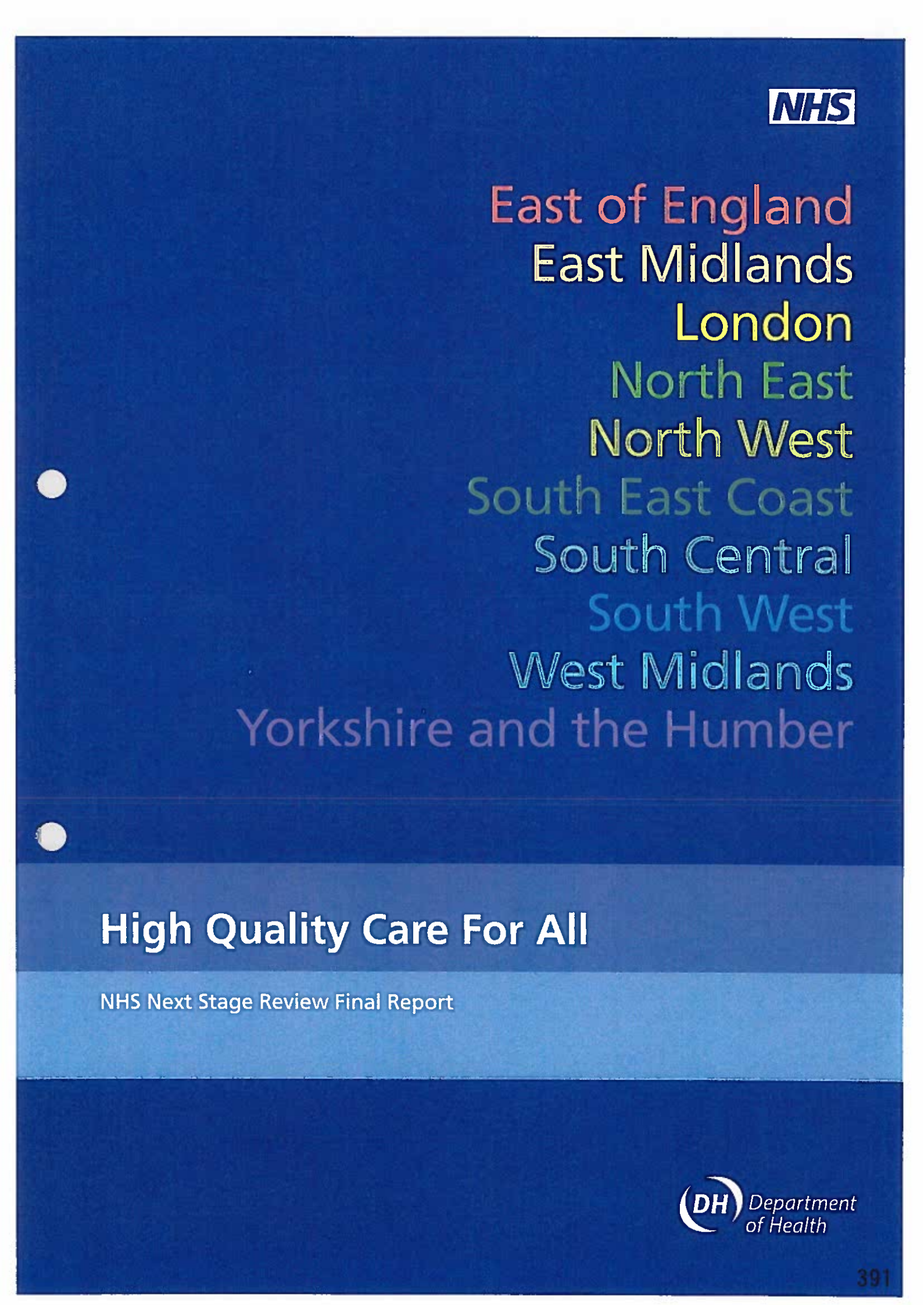
Summary of recommendations

Access and alternatives	1 L	Every emergency department should have a co-located primary care out-of-hours facility
	2 N	Best practice that directs patients to the right care, first time, should be promoted across the NHS so as to minimise repetition of assessment, delays to care and unnecessary duplication of effort
Skill mix / case mix	3 N	All trainee doctors on acute specialty programmes should rotate through the emergency department
	4 L	Senior decision-makers at the front door of the hospital, and in surgical, medical or paediatric assessment units, should be normal practice, not the exception
	5 N	Emergency departments should have the appropriate skill mix and workforce to deliver safe, effective and efficient care
	6 L	At times of peak activity, the system must have the capacity to deploy or make use of extra senior staff
Integration and communities	7 N	Community and social care must be coordinated effectively and delivered 7 days a week to support urgent and emergency care services
	8 L	Community teams should be physically co-located with the emergency department to bridge the gap between the hospital and primary and social care, and to support vulnerable patients
Seven-day service	9 N	The delivery of a seven-day service in the NHS must ensure that emergency medicine services are delivered 24/7, with senior decision makers and full diagnostic support available 24 hours a day, including appropriate access to specialist services
Funding / fair reward	10 N	The funding and targets systems for emergency department attendances and acute admissions are unfit for purpose and require urgent change
	11 N	Delivering 24/7 services requires new contractual arrangements that enable an equitable work–life balance
Information technology	12 L	It is essential that each emergency department and acute admissions unit has an IT infrastructure that effectively integrates clinical and safeguarding information across all parts of the urgent and emergency care system
	13 N	If configured properly with significant senior clinical involvement and advice, NHS 111, NHS 24, NHS Direct and equivalent telephone advice services can help to reduce the pressures on the urgent and emergency care system

Key: L Local recommendations N National recommendations

- **Royal College of Physicians**
  www.rcplondon.ac.uk
- **The College of Emergency Medicine**
  www.collemergencymed.ac.uk
- **Royal College of Paediatrics and Child Health**
  www.rcpch.ac.uk
- **Royal College of Surgeons**
  www.rcseng.ac.uk

Royal College of Physicians | The College of Emergency Medicine | RCPCH Royal College of Paediatrics and Child Health | RCS Advancing Surgical Standards


NHS
East of England
East Midlands
London
North East
North West
South East Coast
South Central
South West
West Midlands
Yorkshire and the Humber
High Quality Care For All
NHS Next Stage Review Final Report
DH Department of Health
391

High Quality Care For All

NHS Next Stage Review Final Report

Presented to Parliament
by the Secretary of State for Health
by Command of Her Majesty

June 2008

CM 7432

£13.90

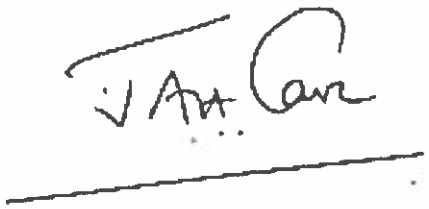
Gateway reference: 10106

Introduction

THE NHS NEXT STAGE REVIEW CLINICAL LEADS IN THE 10 STRATEGIC HEALTH AUTHORITIES

In previous reviews of the NHS, frontline staff have been on the fringes or bystanders. This Review has been different. We and our colleagues in the NHS have been at its core. There has been an unprecedented opportunity for health and social care professionals to review the best available evidence, to discuss priorities with patients and the public, and develop compelling shared visions for our local NHS.

Through this Review, the NHS has created its own ambitious visions for the future of health and healthcare. This marks a real change in the relationship between the frontline NHS and the centre. Lord Darzi and the Department of Health have focused on supporting the improvements we want to make. This report will enable the local NHS to achieve what matters to us, to patients and to the public – improved health and high quality care for all.



Dr James Cave
BSc (Hons) MBBS DRCOG FRCGP
NHS South Central Clinical Lead
General Practitioner, Berkshire West Primary Care Trust

Professor Matthew Cooke
PhD FCEM FRCS (Ed)
NHS West Midlands Clinical Lead
Professor of Emergency Medicine, Heart of England NHS Foundation Trusts and Warwick Medical School

Sir Cyril Chantler
MA MD FRCP FRCPH FMedSci
NHS London Clinical Lead
Chairman, Great Ormond Street Hospital for Children NHS Trust

Professor Peter Kelly
BSc PhD CStat FFPH
NHS North East Clinical Lead
Executive Director of Public Health for Tees Primary Care Trusts

Professor Mayur Lakhani CBE
FRCGP FRCP
NHS East Midlands Joint Clinical Lead
Medical Director, NHS East Midlands Strategic Health Authority

Dr Jonathan P Sheffield
MBChB FRCPath
NHS South West Clinical Lead
Medical Director, University Hospitals Bristol NHS Foundation Trust

Dr Kathy McLean
MBChB FRCP
NHS East Midlands Joint Clinical Lead
Medical Director, Derby Hospitals NHS Foundation Trust

Professor Christopher L Welsh
MA MB MChir FRCS FFOM (Hon)
NHS Yorkshire and the Humber Clinical Lead
Medical Director, Yorkshire and the Humber Strategic Health Authority and Chief Operating Officer, Sheffield Teaching Hospitals NHS Foundation Trust

Mr Edward Palfrey
MA MB BChir FRCS FRCS(Ed)
NHS South East Coast Clinical Lead
Medical Director, Frimley Park Hospital NHS Foundation Trust

Dr Robert Winter
MA MD FRCP
NHS East of England Clinical Lead
Medical Director, Cambridge University Hospitals NHS Foundation Trust

Dr Steve Ryan
MBChB MD
NHS North West Clinical Lead
Medical Director Royal Liverpool Children's NHS Trust

Preface

By the Prime Minister

The National Health Service is not just a great institution but a unique and very British expression of an ideal – that healthcare is not a privilege to be purchased but a moral right secured for all.

For 60 years it has carried the support of the British people because it speaks to our values of fairness and opportunity for all and because it is always there for us when we are most vulnerable and in need.

That is why it is right that we should seek to renew the NHS for the 21st century. To meet the rising aspirations of the public, the changing burdens of disease and to ensure that the very latest, personalised healthcare is available to all of us, not just those able to pay.

Over the last 10 years we have improved the basic standards of the NHS. In 2000, the NHS Plan set out to tackle the challenges which chronic underinvestment had created. Since then we have invested in 80,000 more nurses and 38,000 more doctors, including 5,000 more GPs. Access to care has improved dramatically, and outcomes have improved as a result: 238,000 lives have been saved in the last 11 years as a result of significant improvements in cancer and heart disease survival rates in particular.

This report builds on those reforms and will, I believe, have an even more profound affect on NHS services and our experience of them. If the challenge 10 years ago was capacity, the challenge today is to drive improvements in the quality of care. We need a more personalised NHS, responsive to each of us as individuals, focused on prevention, better equipped to keep us healthy and capable of giving us real control and real choices over our care and our lives.

Lord Darzi's report is a tremendous opportunity to build an NHS that provides truly world class services for all. It requires Government to be serious about reform, committed to trusting frontline staff and ready to invest in new services and new ways of delivering services. It is a bold vision for an NHS which is among the best healthcare systems in the world – a once in a generation opportunity that we owe it to ourselves and our families to take.

I would like to thank Lord Darzi and the thousands of those who have been involved in the review locally and nationally for their contributions. As a Government the renewal of the NHS must be one of our very highest priorities and we will rise to the challenge you have set us.

Gordon Brown

Gordon Brown
Prime Minister

Foreword

By the Secretary of State for Health

On its 60th anniversary, the NHS is in good health.

The NHS touches our lives at times of basic human need, when care and compassion are what matter most. Over the past 60 years, it has been a vital friend to millions of people, sharing their joy and comforting their sorrow.

The service continues to be available to everyone, free at the point of need. One million people are seen or treated every 36 hours, and nine out of 10 people see their family doctor in any given year. In 2008, the NHS will carry out a million more operations than it did just 10 years ago.

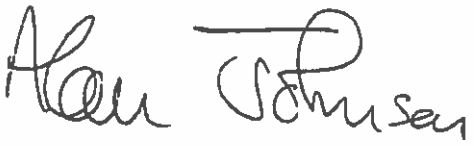
Over the past decade, the NHS budget has trebled. It employs a third more people than it did – more doctors, more nurses, delivering better care for patients. We have invested in new facilities and advanced equipment – last autumn we announced an additional £250 million to improve access to GP services including over 100 new practices in the most deprived areas of the country.

The Prime Minister, Chancellor and I asked Lord Darzi to lead this Review working in partnership with patients, frontline staff and the public to develop a vision of a service fit for the 21st century. He has succeeded. The strength of this Review has been the 2,000 frontline clinicians and other local health and social care staff who have led the process, with thousands more staff, patients and members of the public involved across the country.

The NHS already delivers high quality care to patients in many respects. The NHS Next Stage Review makes a compelling case that it can deliver high quality care for patients in *all* respects. It is only because of the investment and reform of the past decade that this is now possible.

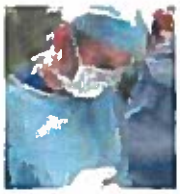
We are also launching an NHS Constitution for consultation. The NHS is as much a social movement as a health service. That is why it is so vital to secure its founding principles and set out the rights and responsibilities of patients, public and staff.

Lord Darzi has led this Review magnificently, bringing to bear huge personal credibility and integrity. I thank him and the thousands of people that have worked to create this Review locally and nationally. It is testament to what we can achieve when everyone in the NHS works together for the benefit of patients.



The Rt Hon Alan Johnson MP
Secretary of State for Health

Contents



Summary letter

Our NHS – Secured today for future generations by Lord Darzi

An NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart.

Dear Prime Minister, Chancellor of the Exchequer, and Secretary of State for Health,

This year the NHS is 60 years old. We are paying tribute to a service founded in adversity, from which were established enduring principles of equal access for all based on need and not ability to pay. We are celebrating a national institution that has made an immeasurable difference to millions of people's lives across the country.

Quite simply, the NHS is there when we need it most. It provides round the clock, compassionate care and comfort. It plays a vital role in ensuring that as many of us as possible can enjoy good health for as long as possible – one of the things that matters most to us and to our family and friends.

The journey so far

I know the journey we have all been on from my own experience as an NHS clinician working in partnership with professional colleagues across the service.

I used to be the only colo-rectal surgeon in my hospital; today I am a member of a team of four surgeons, working in a network that reaches out into primary care. Ten years ago, we had one part-time stoma nurse. Today we have two full-time stoma nurses, two specialist nurses and a nurse consultant.

Ten years ago, my patients would sometimes wait over a year for treatment, and now they wait just a few weeks – and even less if cancer is suspected. My patients are treated using keyhole surgery enabling them to leave hospital in days rather than weeks. My team's conversations about quality take place in weekly multidisciplinary meetings rather than in corridors. Together, these changes have meant real improvements for patients.

I have seen for myself the NHS getting better, and I have heard similar stories from other clinical teams throughout the country over the course of this Review. These achievements were enabled by the investment of extra resources,[1] by giving freedom to the frontline through NHS foundation trusts, and by ensuring more funding followed patient choices. They were delivered by the dedication and hard work of NHS staff who were determined to improve services for patients and the public.

1 In 1996/7, the budget for the NHS in England was £33 billion; in 2008/9 it is £96 billion.

The next stage of the journey

My career is dedicated to improving continuously the quality of care we provide for patients. This is what inspires me and my professional colleagues, and it has been the guiding principle for this Review. We need to continue the NHS journey of improvements and move from an NHS that has rightly focused on increasing the quantity of care to one that focuses on improving the quality of care.

There is still much more to do to achieve this. I have continued my clinical practice while leading the Review nationally. I have seen and treated patients every week. Maintaining that personal connection with patients has helped me understand the improvements we still need to make. It has driven me to focus this Review on practical action.

It is because of this that I have been joined in this Review by 2,000 clinicians and other health and social care professionals from every NHS region in England. Their efforts, in considering the best available evidence and in setting out their own visions for high quality services (described in *Chapter 1*), have been the centrepiece of this process.

Their visions – developed in discussion with patients, carers and members of the general public – set out bold and ambitious plans. I am excited by the local leadership they demonstrate and the commitment of all those who have been involved.

In developing the visions, the NHS has had to face up to significant variations in the quality of care that is provided. Tackling this will be our first priority. The NHS needs to be flexible to respond to the needs of local communities, but people need to be confident that standards are high across the board.

Delivering the visions will mean tackling head on those variations in the quality of care and giving patients more information and choice. The message they send is that the programme of reform that has been put in place has been unevenly applied and can go much further.

We also need to accelerate change for other reasons. *Chapter 2* describes the changes facing society and healthcare systems around the world. It sets out how the NHS in the 21st century faces a particular set of challenges, which I would summarise as: rising expectations; demand driven by demographics; the continuing development of our 'information society'; advances in treatments; the changing nature of disease; and changing expectations of the health workplace. These are challenges we cannot avoid. The NHS should anticipate and respond to the challenges of the future.

My conclusions, and the measures described in this report, focus on how we can accelerate the changes that frontline staff want to make to meet those challenges, whilst continuing to raise standards.

The vision this report sets out is of an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically

effective, personal and safe. It will see the NHS deliver high quality care for all users of services in all aspects, not just some. I set out below the key steps we must take to deliver this vision.

High quality care for patients and the public

Throughout this Review, I have heard clearly and consistently that people want a greater degree of control and influence over their health and healthcare. If anything, this is even more important for those who for a variety of reasons find it harder to seek out services or make themselves heard.

Personalising services means making services fit for everyone's needs, not just those of the people who make the loudest demands. When they need it, all patients want care that is personal to them.[2] That includes those people traditionally less likely to seek help or who find themselves discriminated against in some way. The visions published in each NHS region make clear that more support is needed for all people to help them stay healthy and particularly to improve the health of those most in need. *Chapter 3* explains how we will do this including by introducing new measures to:

Create an NHS that helps people to stay healthy. For the NHS to be sustainable in the 21st century it needs to focus on improving health as well as treating sickness. This is not about the 'nanny state'. As a clinician, I believe that the NHS has a responsibility to promote good health as well as tackle illness.

Achieving this goal requires the NHS to work in partnership with the many other agencies that also seek to promote health. Much progress on closer working has been made in recent years. In line with my terms of reference,[3] this reports focuses on what the NHS can do to improve the prevention of ill health.

The immediate steps identified by this Review are:

- **Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations**. Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving sexual health and improving mental health.

- **A Coalition for Better Health, with a set of new voluntary agreements between the Government, private and third sector organisations on actions to improve health outcomes**. Focused initially on combatting obesity, the Coalition will be based on agreements to ensure healthier food, to get more people more physically active, and to encourage companies to invest more in the health of their workforce.

2 Opinion Leader Research, Key findings of 18 September 2007 *Our NHS, Our Future* nationwide consultative event.

3 Terms of Reference available at www.ournhs.nhs.uk

- **Raised awareness of vascular risk assessment through a new 'Reduce Your Risk' campaign**. As we roll out the new national programme of vascular risk assessment for people aged between 40 and 74, we will raise awareness through a nationwide 'Reduce Your Risk' campaign – helping people to stay healthy and to know when they need to get help.

- **Support for people to stay healthy at work**. We will introduce integrated Fit for Work services, to help people who want to return to work but are struggling with ill health to get back to appropriate work faster.

- **Support GPs to help individuals and their families stay healthy**. We will work with world-leading professionals and patient groups to improve the Quality and Outcomes Framework to provide better incentives for maintaining good health as well as good care.

We will give patients more rights and control over their own health and care. I have heard the need to give patients more information and choice to make the system more responsive to their personal needs. We will:

- **Extend choice of GP practice**. Patients will have greater choice of GP practice and better information to help them choose. We will develop a fairer funding system, ensuring better rewards for GPs who provide responsive, accessible and high quality services. The NHS Choices website will provide more information about all primary and community care services, so that people can make informed choices.

- **Introduce a new right to choice in the first NHS Constitution**. The draft NHS Constitution includes rights to choose both treatment and providers and to information on quality, so that, wherever it is relevant to them, patients are able to make informed choices.

- **Ensure everyone with a long-term condition has a personalised care plan**. Care plans will be agreed by the patient and a named professional and provide a basis for the NHS and its partners to organise services around the needs of individuals.

- **Pilot personal health budgets**. Learning from experience in social care and other health systems, personal health budgets will be piloted, giving individuals and families greater control over their own care, with clear safeguards. We will pilot direct payments where this makes most sense for particular patients in certain circumstances.

- **Guarantee patients access to the most clinically and cost effective drugs and treatments**. All patients will receive drugs and treatments approved by the National Institute for Health and Clinical Excellence (NICE) where the clinician recommends them. NICE appraisals processes will be speeded up.

The common theme of these new measures for patients is improving quality. It must be the basis of everything we do in the NHS.

Quality at the heart of the NHS

In my career as a surgeon, I try to do my best to provide patients with high quality NHS care – just like hundreds of thousands of other staff. This has been my guiding principle as I have led this Review.

High quality care should be as safe and effective as possible, with patients treated with compassion, dignity and respect. As well as clinical quality and safety, quality means care that is personal to each individual.

As independent research has shown,[4] the NHS has made good progress over the past decade in improving the overall quality of care for patients. During this period, improvements in quality were focused primarily on waiting times, as basic acceptable standards of access to A&E and secondary care were established, and on staffing levels and physical infrastructure.

Today, with the NHS budget approaching £2 billion a week, more staff, and improvements in the quality and availability of information, quality can be at the heart of everything we do in the NHS. It means moving from high quality care in some aspects to high quality care in all.

We will raise standards. The visions set out for each NHS region and formed by patients' expectations are ambitious for what the NHS can achieve. *Chapter 4* of this report sets out the measures that will enable us to meet these standards:

- **Getting the basics right first time, every time**. We will continue to seek improvements in safety and reductions in healthcare associated infections. The Care Quality Commission will have new enforcement powers. There will be national campaigns to make care even safer.

- **Independent quality standards and clinical priority setting**. NICE will be expanded to set and approve more independent quality standards. A new National Quality Board will offer transparent advice to Ministers on what the priorities should be for clinical standard setting by NICE.

- **For the first time we will systematically measure and publish information about the quality of care from the frontline up**. Measures will include patients' own views on the success of their treatment and the quality of their experiences. There will also be measures of safety and clinical outcomes. All registered healthcare providers working for, or on behalf of, the NHS will be required by law to publish 'Quality Accounts' just as they publish financial accounts.

4 S Leatherman and K Sutherland, *The Quest for Quality: Refining the NHS Reforms*, Nuffield Trust, May 2008 and K Davis et al., *Mirror, Mirror on the Wall: An international update on the comparative performance of American healthcare*, Commonwealth Fund, May 2007

- **Making funding for hospitals that treat NHS patients reflect the quality of care that patients receive**. For the first time, patients' own assessments of the success of their treatment and the quality of their experiences will have a direct impact on the way hospitals are funded.

- **For senior doctors, the current Clinical Excellence Awards Scheme will be strengthened, to reinforce quality improvement**. New awards, and the renewal of existing awards, will become more conditional on clinical activity and quality indicators; and the Scheme will encourage and support clinical leadership of service delivery and innovation.

- **Easy access for NHS staff to information about high quality care**. All NHS staff will have access to a new NHS Evidence service where they will be able to get, through a single web-based portal, authoritative clinical and non-clinical evidence and best practice.

- **Measures to ensure continuous improvement in the quality of primary and community care**. We have just completed our consultation on proposals to bring all GP practices and dental practices within the scope of the new health and adult social care regulator, the Care Quality Commission.[5] We will introduce a new strategy for developing the Quality and Outcomes Framework which will include an independent and transparent process for developing and reviewing indicators. We will support practice accreditation schemes, like that of the Royal College of General Practitioners.

- Developing **new best practice tariffs focused on areas for improvement**. These will pay for best practice rather than average cost, meaning NHS organisations will need to improve to keep up.

We will strengthen the involvement of clinicians in decision making at every level of the NHS. As this Review has shown, change is most likely to be effective if it is led by clinicians. We will do this by ensuring that:

- **Medical directors and quality boards feature at regional and national level.** These will complement the arrangements at PCT level that are developing as part of the World Class Commissioning programme.

- **Strategic plans for delivering the visions will be published later this year by every primary care trust**. Change will be based on the five principles I set out earlier this year in *Leading Local Change*.[6]

- There is clear **local support for quality improvement**. A new 'Quality Observatory' will be established in every NHS region to inform local quality improvement efforts.

5 Department of Health, *The future regulation of health and adult social in England*, 25 March 2008.

6 *NHS Next Stage Review: Leading Local Change*, Department of Health, May 2008.

We will foster a pioneering NHS. Throughout my career, in all the clinical teams I have worked in, my colleagues and I have challenged one another to improve the way we provide care for patients. Continuous advances in clinical practice mean the NHS constantly has the opportunity to improve. My review will enable this through:

- **Introducing new responsibilities, funds and prizes to support and reward innovation.** Strategic health authorities will have a new legal duty to promote innovation. New funds and prizes will be available to the local NHS.

- **Ensuring that clinically and cost effective innovation in medicines and medical technologies is adopted**. We will strengthen the horizon scanning process for new medicines in development, involving industry systematically to support better forward planning and develop ways to measure uptake. For new medical technologies, we will simplify the pathway by which they pass from development into wider use, and develop ways to benchmark and monitor uptake.

- **Creating new partnerships between the NHS, universities and industry.** These 'clusters' will enable pioneering new treatments and models of care to be developed and then delivered directly to patients.

These changes will help the NHS to provide high quality care across the board. Throughout this Review, it has been clear that high quality care cannot be mandated from the centre – it requires the unlocking of the talents of frontline staff.

Working in partnership with staff

I have heard some people claim that there is 'change fatigue' in the NHS. I understand that NHS staff are tired of upheaval – when change is driven top-down. It is for this reason that I chose to make this Review primarily local, led by clinicians and other staff working in the NHS and partner organisations. In my own practice and across the country I have seen that, where change is led by clinicians and based on evidence of improved quality of care, staff who work in the NHS are energised by it and patients and the public more likely to support it.

We will empower frontline staff to lead change that improves quality of care for patients. *Chapter 5* sets out how we will do this by:

- **Placing a new emphasis on enabling NHS staff to lead and manage the organisations in which they work**. We will re-invigorate practice-based commissioning and give greater freedoms and support to high performing GP practices to develop new services for their patients, working with other primary and community clinicians. We will provide more integrated services for patients, by piloting new integrated care organisations, bringing together health and social care professionals from a range of organisations – community

services, hospitals, local authorities and others, depending on local needs.

- **Implementing wide ranging programme to support the development of vibrant, successful community health services**. Where PCTs and staff choose to set up social enterprise organisations, transferred staff can continue to benefit from the NHS Pension Scheme while they work wholly on NHS funded work. We will also encourage and enable staff to set up social enterprises by introducing a 'staff right to request' to set up social enterprises to deliver services.

- **Enhancing professionalism**. There will be investment in new programmes of clinical and board leadership, with clinicians encouraged to be practitioners, partners and leaders in the NHS. We challenge *all* organisations that do business as part of, or with, the NHS to give clinicians more control over budgets and HR decisions.

- **No new national targets** are set in this report.

We will value the work of NHS staff. NHS staff make the difference where it matters most and we have an obligation to patients and the public to enable them to make best use of their talents. That is why the Review announces in *Chapter 6*:

- **New pledges to staff**. The NHS Constitution makes pledges on work and wellbeing, learning and development, and involvement and partnership. All NHS organisations will have a statutory duty to have regard to the Constitution.

- **A clear focus on improving the quality of NHS education and training**. The system will be reformed in partnership with the professions.

- **A threefold increase in investment in nurse and midwife preceptorships**. These offer protected time for newly qualified nurses and midwives to learn from their more senior colleagues during their first year.

- **Doubling investment in apprenticeships**. Healthcare support staff – clinical and non-clinical – are the backbone of the service. Their learning and development will be supported through more apprenticeships.

- **Strengthened arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills**. Sixty per cent of staff who will deliver NHS services in 10 years time are already working in healthcare.We need to make sure that they are able to keep their skills and knowledge up to date.

The first NHS Constitution

You asked me to consider the case for an NHS Constitution. In *Chapter 7*, I set out why I believe it will be a powerful way to secure the defining features of the service for the next generation. I have heard that whilst changes must be made to improve quality, the best of the NHS, the values and core principles which

underpin it, must be protected and enshrined. An NHS Constitution will help patients by setting out, for the first time, the extensive set of legal rights they already have in relation to the NHS. It will ensure that decision-making is local where possible and more accountable than it is today, providing clarity and transparency about who takes what decisions on our behalf.

Finally, *Chapter 8* sets out how we will deliver this ambitious programme.

Conclusion

In the 21st century, there remains a compelling case for a tax-funded, free at the point of need, National Health Service. This Report celebrates its successes, describes where there is clear room for improvement, looks forward to a bright future, and seeks to secure it for generations to come through the first NHS Constitution. The focus on prevention, improved quality and innovation will support the NHS in its drive to ensure the best possible value for money for taxpayers. It is also an excellent opportunity to pursue our duties to promote equality and reduce discrimination under the Equality and Human Rights Act.

Through this process, we have developed a shared diagnosis of where we currently are, a unified vision of where we want to be and a common language framework to help us get there. This Review has built strong foundations for the future of the service. It outlines the shape of the next stage of reform, with the clarity and flexibility to give confidence for the future.

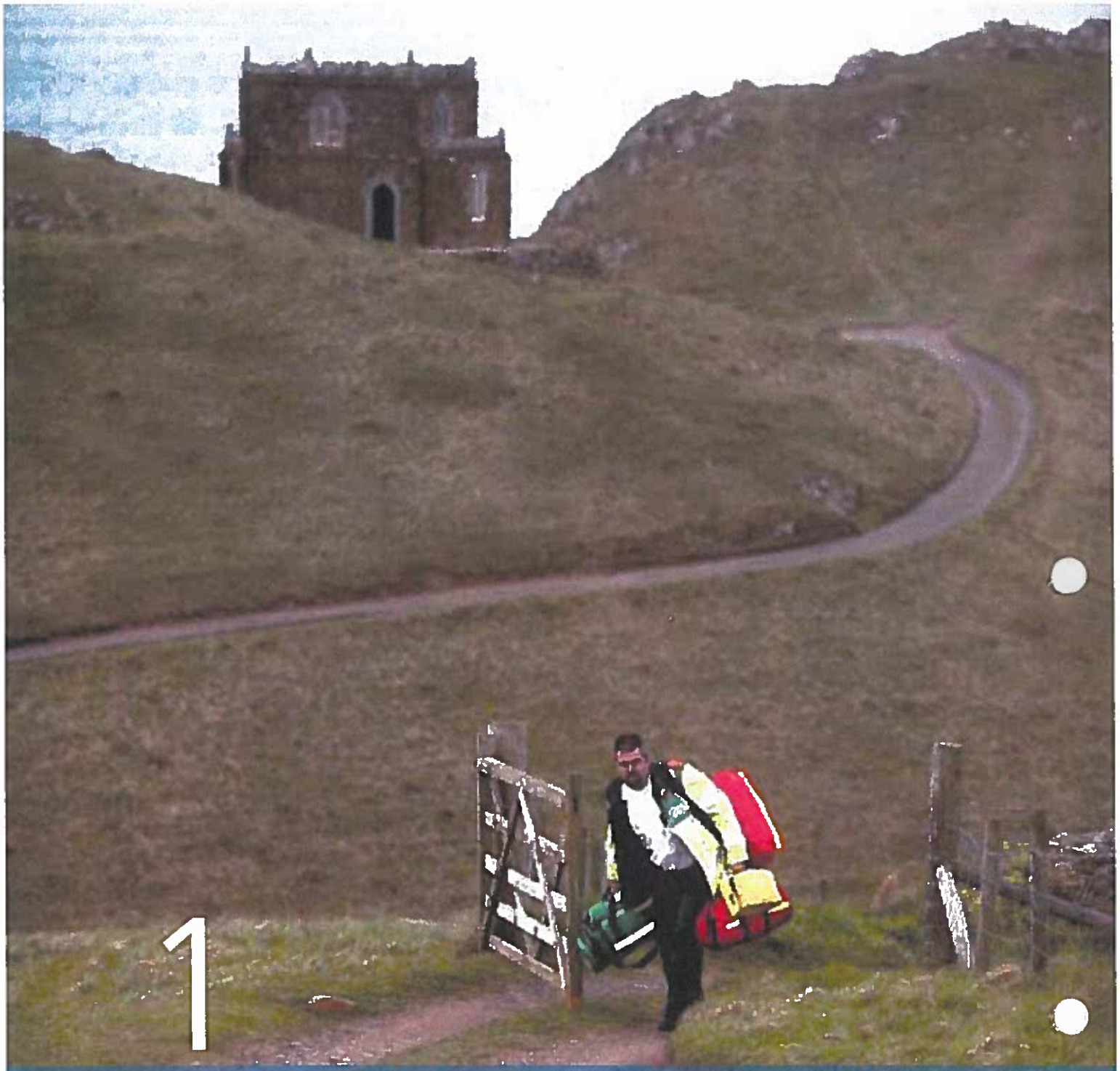
Leadership will make this change happen. All of the 2,000 frontline staff that have led this Review have shown themselves to be leaders by having the courage to step up and make the case for change. Their task has only just begun – it is relatively easy to set out a vision, much harder to make it a reality. As they strive to make change happen, they can count on my full support.

I would like to thank everyone who has participated in this Review. I am grateful for the help they have given to me in forming and shaping the conclusions of this Report.

Best wishes,

Professor the Lord Darzi of Denham KBE
Hon FREng, FMedSci
Parliamentary Under Secretary of State

Paul Hamlyn Chair of Surgery,
Imperial College London
Honorary Consultant Surgeon,
Imperial College Healthcare NHS Trust
and the Royal Marsden Hospital
NHS Foundation Trust



1

Change – locally-led, patient-centred and clinically driven

A nationwide process – the core of the NHS Next Stage Review

An emergency care practitioner from the Cornwall Ambulance Service responds to a call in Port Quin, Cornwall

1

Change – locally-led, patient-centred and clinically driven

A nationwide process – the core of the NHS Next Stage Review

1. The challenge for this Review, set out in my terms of reference, was to "help local patients, staff and the public in making the changes they need and want for their local NHS."[7] This approach was necessary because change is best when it is determined locally. Changing well-loved services can be unsettling for patients, public and staff. Therefore, it is important that the local NHS goes through a proper process to determine what will work best, involving patients, carers, the general public and staff, whilst communicating clearly throughout.

2. This has meant a very different type of Review, one driven by the NHS itself. Over the past few months, each region of the NHS has published its vision for improving health and healthcare services.

3. These visions are the product of the work more than 2,000 clinicians and other staff in health and social care, who have shown tremendous leadership in creating, shaping and forming the conclusions. In each region, they have met in eight or more groups reflecting different 'pathways of care' – from maternity and newborn care through to end of life care.[8] These groups have considered the best available clinical evidence, worked in partnership with thousands of patients, listened to the needs and aspirations of the public and set out comprehensive and coherent visions for the future.

4. The visions are the centrepiece of this Review – they report much progress, but also identify where, based on clinical evidence, further change is required in order to provide high quality care. They show how the NHS is responding to people's needs throughout their lives, from before birth, through childhood and adolescence and into adulthood and old age. They describe the priorities for action and explain what difference these priorities, once implemented, will make for local populations.

5. The proposals will allow NHS services everywhere to reflect the needs of their local communities. People and communities across England have different characteristics and different needs. Yet too often, the services they receive are not sufficiently shaped around those characteristics and needs. If the NHS is to live up

7 The terms of reference are available at www.ournhs.nhs.uk

8 Some of the strategic health authorities chose to create more than eight groups. South West SHA for instance had a group looking at the best care for people with learning disabilities

1

to its founding principles, it must constantly respond to those it serves, changing to continue to live up to the ambition of high quality care. The NHS should be universal, but that does not mean that it should be uniform. Clear minimum standards and entitlements will exist, but not a one size fits all model.

6. These visions are the start of responding to local needs. They describe an NHS that will work with partner organisations locally to reach out and help people stay healthy, and, when people do need care, provide convenient, high quality care. Services will be found in the community, with family doctors, pharmacies and local partnerships taking a leading role in helping people to stay healthy. In future, the NHS will not be confined to hospitals, health centres or GP surgeries but will be available online and in people's homes, whilst the most specialist care will be concentrated to allow excellence to flourish.

7. Although the specific steps in each region's vision varied as the clinical working groups found the best solutions for their local populations, their reports include some important common messages:

   - The **staying healthy** groups identified the need to support people to take responsibility for their own health, through reaching out to disadvantaged groups. They also highlighted the expansion of comprehensive screening and immunisation programmes.

   - The **maternity and newborn** groups were clear that women want high quality, personal care with greater choice over place of birth, and care provided by a named midwife.

   - For the **children's** pathway, it was felt that services need to be more effectively designed around the needs of children and families, delivered not just in health settings but also in schools and children's centres.

   - The **acute care** groups gave compelling arguments for saving lives by creating specialised centres for major trauma, heart attack and stroke care, supported by skilled ambulance services.

   - Those looking at **planned care** found more care could, and should, be provided closer to people's homes, with greater use of technology, and outpatient care not always meaning a trip to hospital.

   - For **mental health**, the groups recognised the importance of extending services in the community, and the benefits to general wellbeing and to physical from stronger mental health promotion.

- The **long-term conditions** groups explained the need for true partnerships between people with long-term conditions and the professionals and volunteers that care for them, underpinned by care plans and better patient information.

- The necessity for greater dignity and respect at the **end of life** was movingly described by the end of life groups, as well as the desire to have round the clock access to palliative services.

8. It is impossible to do justice here to the breadth of ambition within the local visions – they demand to be read.[9] However, we can illustrate important themes with specific local promises.

Preventing ill health

9. There is a clear consensus across the service that the NHS must help people to lead independent and fulfilling lives by supporting them to stay healthy. The local NHS wants to work with others to help people stop smoking, to address obesity in children and adults, and to tackle excessive alcohol consumption. In the East of England, for example, patients, the public and staff have set themselves the ambition of reducing the number of smokers in their region by 140,000, from its current level of a million.[10] They are developing plans for a social marketing campaign to encourage people to take responsibility for their own health throughout their lives, whilst reaching out to the most disadvantaged in society to help them to stay healthy.

Ensuring timely access

10. There was a strong message that people can still find it difficult to access services. Improving access is a priority articulated in every vision, across every pathway of care. Each region will continue to improve the quality of access by reducing waiting times for treatment, whilst ensuring that services are available regardless of where a patient lives. The plans to improve dementia services in the West Midlands, and South Central's goal to deliver round the clock palliative care for children, are just two of the many examples where the local NHS will transform access to services for patients.[11]

Providing convenient care closer to home

11. The local visions will make care closer to home a reality for many patients. For instance, in London, there are plans to deliver more outpatient appointments in community settings and carry out routine and straightforward procedures in GP practices, where appropriate.[12]

9 The local visions are available at www.ournhs.nhs.uk

10 NHS East of England, *Towards the best, together*, May 2008.

11 NHS West Midlands, *Delivering Our Clinical Vision for a World Class Health Service*, June 2008 and NHS South Central, *Towards a Healthier Future*, June 2008.

12 NHS London, *Healthcare for London: A Framework for Action*, July 2007.

1

NHS North West is making specialist knowledge more locally available through the use of cardiac telemedicine in GP practices.[13] This allows GPs to make a diagnosis, with the help of specialists at the end of a phone, in their own surgeries.

Improved diagnostics

12. All the visions emphasised the importance of rapid access to diagnostics in convenient locations.[14] On the one hand, this means tests such as x-rays and blood tests carried out in primary care or even at patients' homes, avoiding needless travel to and from hospital and with results made available more quickly. On the other, it means provision of interventional radiology and specialist pathology in centres of excellence. To make this a reality, it will be important to take into account Lord Carter's review of pathology services[15] and draw on the expertise of professional bodies.

Giving more control to patients

13. The NHS locally is seeking to forge a new partnership between professionals, patients and their carers. NHS North East, for example, is searching for new ways to integrate care around the needs of patients, including community services.[16] There will be more use of assistive technology and remote monitoring to help patients lead independent lives. It is suggested that patients should have more direct control over NHS spending – for instance, NHS Yorkshire and the Humber has called for the consideration of personal budgets for people with complex long-term conditions.[17]

Ensuring care is effective and safe

14. The visions have sent a powerful message that the most effective treatments should be available for all NHS patients. Their plans for transforming treatment for heart attack, stroke and major trauma vividly illustrate this. For stroke – the third largest cause of death and single largest cause of disability in the UK – the clinical evidence clearly demonstrates that the quality of care is greatly improved if stroke is treated in specialist centres.[18] Each region is therefore pushing forward with the development of specialised centres for their populations with access to 24/7 brain imaging and thrombolysis delivered by expert teams. For example, by 2010, NHS South East Coast intends that all strokes, heart attacks and major injuries will be treated in such specialist centres.[19] Once implemented, these plans will save lives. From every corner of the NHS, there was also a strong emphasis on the importance of patient safety. They all aim to make hospitals and health centres clean and as free of infection as possible.

13 NHS North West, *Healthier Horizons*, May 2008.
14 See for instance, NHS West Midlands, *Delivering Our Clinical Vision for a World Class Health Service*, June 2008.
15 Lord Carter, *Report of the Review of NHS Pathology Services in England*, 2006.
16 NHS North East, *Our vision, our future*, June 2008.
17 NHS Yorkshire and the Humber, *Healthier Ambitions*, May 2008.
18 A. Buchan, Best practice in Stroke Care 2007, presentation at the Healthcare for London conference, 19 February 2007.
19 NHS South East Coast, *Healthier People, Excellent Care*, June 2008.

15. The visions also emphasise the importance of geographical factors in the effectiveness and safety of care. This was reinforced by a submission report to this Review by the Commission for Rural Communities.[20]

High quality care

16. From the vision documents, and from my own visits to every region of the country, the message that improving quality of care is what excites and energises NHS staff has been loud and clear. International evidence shows that we have made great improvements but that there is further to go. Nolte and McKee have found that the NHS made a 21 per cent reduction in premature mortality rates from 1997–98 to 2002–03, compared to a 4 per cent reduction by the US.[21] However, there is much more to do, as our starting point was worse than our international comparators.

17. Every region of the NHS has articulated its aspiration for high quality care for their populations. NHS South West, for example, has set a goal of matching the longest life expectancy in Europe.[22] Using clinical expertise, NHS East Midlands will publish standard quality measures allowing patients to compare the performance of different providers.[23]

20 Commission for Rural Communities, *Tackling rural disadvantages*, May 2008
21 E. Nolte and N. McKee, "Measuring the Health of Nations, updating an earlier analysis, 2008," *Health Affairs* 27 10, 58–71
22 NHS South West, *Improving Health*, May 2008
23 NHS East Midlands, *From Evidence to Excellence*, June 2008.

Personal care

18. All the visions emphasised the need to organise care around the individual, meeting their needs not just clinically, but also in terms of dignity and respect. NHS South West, for instance, recognised that the best diabetes services are tailored to individuals, comprising a mix of structured education, lifestyle advice and appropriate screening.[24] Personal care also considers the needs of the patient within the context of their support network, including carers, family and employers.

Innovation

19. The desire to bring the benefits of innovation to patients more rapidly is a common theme. Across the country, from the South West to the North East, we heard that there is much to be gained by the NHS working in partnership with higher education institutions and the private sector. And there is very strong support for greater collaboration between primary, secondary and social care.

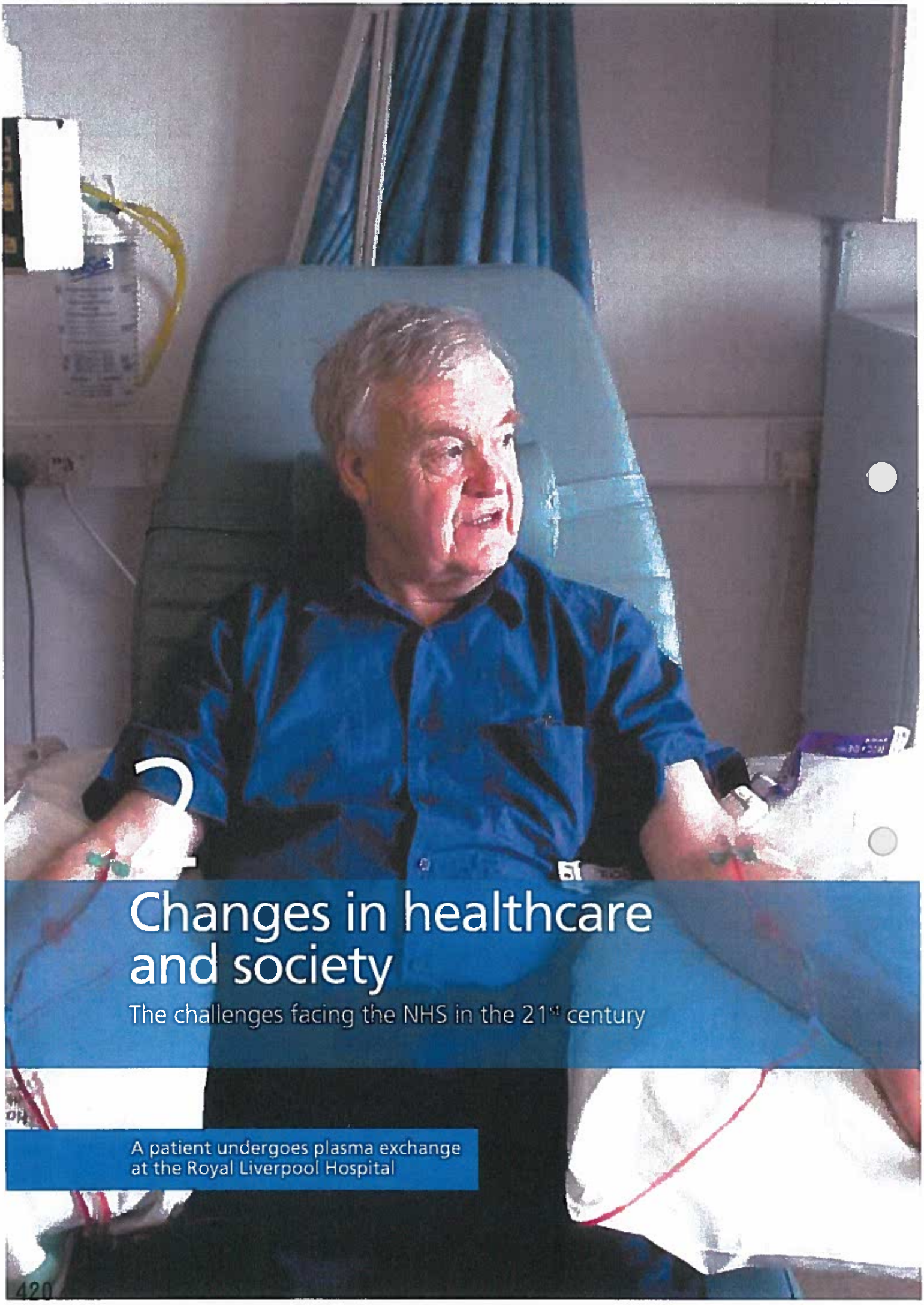
20. These are the changes patients and public can expect to see. However, there was one more common theme – all the local visions made the case for national action to enable local change. This report therefore sets out how we will help the local NHS to ensure that the pace of change does not slow and that the expectations of patients and the public are met. It describes how we will respond to the challenges the visions set, helping patients, the public and frontline staff to achieve their collective ambitions.

24 NHS South West, *Improving Health*, May 2008.

1

21. This report addresses big national themes such as improving quality, leadership and the workforce.[25] It focuses on what must be done centrally to support local organisations. It illustrates that the role of the Department of Health is to enable the visions created by the local NHS to become a reality, whilst ensuring that universality, minimum standards and entitlements are retained and strengthened. It sets out how we will back local leaders to deliver for their communities.

25 National Groups were established as part of the Review in October 2007 on Quality and Safety, Leadership, Primary and Community Care, Workforce, and Innovation.



Changes in healthcare and society

The challenges facing the NHS in the 21st century

A patient undergoes plasma exchange at the Royal Liverpool Hospital

2

Changes in healthcare and society

The challenges facing the NHS in the 21st century

1. Every SHA vision identified the challenges faced in their region of the country.[26] Drawing together the common themes, it is possible to take a national perspective. The drivers for change in healthcare and society are beyond the control of any single organisation. Nor can they be dealt with simply or reactively at national level. This reinforces the case for enabling and encouraging the NHS locally to anticipate and respond proactively to the challenges of the future.

2. In its earliest years, the NHS faced significant challenges to provide basic care when people fell sick and to tackle communicable diseases. Nowadays, diseases such as measles, polio and diphtheria, previously common and deadly to the post-war generation, are rare and preventable, thanks to vaccination programmes, and treatable, thanks to advances in research and technology.

3. Nationally, the NHS in the 21st century faces different challenges, which I would summarise as: rising expectations; demand driven by demographics; the continuing development of our 'information society'; advances in treatments; the changing nature of disease; and changing expectations of the health workplace.

4. These six challenges are not limited to England – they are common to all advanced health systems, most of which are considering or undertaking significant reforms in response.[27] Not all the challenges are unique to healthcare – their impact is being felt across public services. The Government is committed to transforming adult social care, for example, so that people have more choice and control over integrated, high quality services.[28] In addressing these challenges for the NHS we have the opportunity to set a direction for wider public service reform.

Challenge 1: Ever higher expectations

5. Wealth and technology have changed the nature of our society's outlook and expectations. The 1942 Beveridge Report[29] identified the 'Five Giants' – want, disease, ignorance, squalor and idleness – that a civilised

26 See for instance *Healthcare for London the Case for Change*.

27 For an influential examination of the need to reform the US health system see Porter and Teisberg, *Redefining Health Care*, 2006.

28 *Putting People First, A shared vision and commitment to the transformation of adult social care*, HM Government, December 2007

29 *Report of the Inter-Departmental Committee on Social Insurance and Allied Services*, Crown Copyright (1942).

2

society needed collectively to address. In 1946, the Labour government legislated for the creation of a National Health Service, and through the leadership of Nye Bevan the NHS was born on 5 July 1948. As an information leaflet from the time explained, its purpose was simple: to "relieve your money worries in time of illness."[30]

6. We tend to use health services at particular stages of our lives, so health professionals are especially exposed to each generation's demands and expectations. We can anticipate these changing demands, and in so doing equip the health service to deal with the future.

7. For those in later life, health practitioners will see a generation with expectations of more tailored treatment received at a time and place convenient to them. As people continue to live longer, they will continue to access services for longer, and are likely to live more of their life with one or more long-term condition.[31] They will make demands that are not just larger but different. They still expect the clinician to lead, but expect a bigger role for themselves in decision-making during their care.

8. We are also beginning to see the impact, and opportunities, that face us from recent generations – the children of the last three decades of the 20th century. These generations are influenced by new technologies that provide unprecedented levels of control, personalisation and connection. They expect not just services that are there when they need them, and treat them how they want them to, but that they can influence and shape for themselves. Better still, they will want services that 'instinctively' respond to them using the sophisticated marketing techniques used by other sectors.[32] This is more than just a challenge for healthcare, but for our whole model of how we think about *health*.

Challenge 2: Demand driven by demographics

9. The fact that people are living longer than ever is a cause for celebration. The NHS can be justly proud of the part it has played in our ever-growing life expectancy. Yet our ageing population also poses a challenge to the sustainability of the NHS. By 2031, the number of over 75 year-olds in the British population will increase from 4.7 million to 8.2 million.[33] This older age group uses a disproportionate amount of NHS resources; the average over-85 year old is 14 times more likely to be admitted to hospital for medical reasons than the average 15-39

30 *The New National Health Service*, Central Office of Information for the Ministry of Health, Crown Copyright (1948).

31 See Wanless, *Securing our Future Health* (2002) for an explanation on how the NHS must not simply help people live longer, but must also ensure that those extra years are active, high quality ones.

32 For instance the personal recommendations given by Amazon and other internet retailers.

33 Office of National Statistics, *Population Projections*, 23 October 2007.

year old.[34] Whilst just 17 per cent of the under 40s have a long-term condition, 60 per cent of the 65 and over age group suffer from one or more.[35]

10. If the NHS remains a primarily reactive service, simply admitting people into hospital when they are ill, it will be unable to cope with the increased demands of an ageing population. Our longer life spans require the NHS to be forward-looking, proactively identifying and mitigating health risks.

Challenge 3: Health in an age of information and connectivity

11. Across society, the internet has transformed our relationship with information. High-speed web access is found in millions of homes. By 2012, 74 per cent of UK homes are expected to have broadband internet access, transforming how people will seek and use information in their lives.[36]

12. The implications for health and healthcare are profound. It is easier to access information on how to stay healthy than ever before. People are able to quickly and conveniently find information about treatment and diseases in a way that was previously impossible. They are able, and want, to engage with others online, sharing information and experiences. They want to do their own research, reflect on what their clinicians have told them and discuss issues from an informed position. The challenge is ensuring that people are able to access reliable information. Evidence shows that clinicians have sometimes been slower in exploiting the potential of new information sources, such as the internet, than others.[37] If that trend continues, there is a danger that people will have to navigate through myth and hearsay, rather than get easy access to evidence-based medical knowledge.

Challenge 4: The changing nature of disease

13. The NHS in the 21st century increasingly faces a disease burden determined by the choices people make: to smoke, drink excessively, eat poorly, and not take enough exercise. Today, countless years of healthy life are lost as the result of these known behavioural or lifestyle factors.

14. Wealth and technology have given us many choices, including ones that are damaging to our health and wellbeing. We drive to work and school instead of walking or cycling; we eat high fat, high salt diets when fresh fruit and vegetables are available in unprecedented volumes; and we consume more alcohol than is good for us.[38]

34 Hospital Episode Statistics Data 2005/06.
35 Department of Health, *Raising the Profile of Long-term Conditions: A Compendium of Information*, January 2008.
36 UK Broadband Overview, January 2008, http://point-topic.com/content/operatorSource/profiles2/uk-broadband-overview.htm
37 Kaimal AJ et al. "Google Obstetrics: who is educating our patients?" *American Journal of Obstetrics and Gynecology*, June 2008, 198(6):682.e1-5.
38 In the ten years to 2003, the number of walking trips fell by 20% (National Statistics 2004). The average number of cycling journeys fell from 20 person per year in 1992/1994 to 16 in 2002/2003 (DfT). 1 in 4 adults (10 million) regularly exceed the recommended daily limits of 2-3 units (women) and 3-4 units (men) (ONS General Household Survey 2006).

2

15. We know that the choices people make when faced with this increasing range of possibilities are strongly influenced by their circumstances. Stress, income, employment prospects and environmental factors constrain the healthy choices open to people, and can make short-term choices more attractive despite adverse health consequences in the longer term. The health service is not always good enough at helping people make the right choices – 54 per cent of patients said that their GP had not provided advice on diet and exercise, whilst 72 per cent said that their GP had not asked about emotional issues affecting their health during the last two years. We lag behind our peers internationally.[39]

16. Unhealthy choices and missed prevention opportunities are in part the cause of the growth in the prevalence of conditions such as diabetes, depression, and chronic obstructive pulmonary disease. The WHO estimates that depression, for instance, will be second only to HIV/AIDS as a contributor to the global burden of disease by 2030, up from fourth place today.[40] These diseases cannot always be cured, but they can be managed, and the symptoms ameliorated.

17. The NHS and all of its many partners must respond to this shifting disease burden and provide personalised care for long-term conditions, a goal already set out in the Government's *Our health, our care, our say* White Paper.[41] We need to make this goal a reality. Providing personalised care should also help us to reduce health inequalities, as the households with the lowest incomes are most likely to contain a member with a long-term condition.[42]

Challenge 5: Advances in treatments

18. The past 60 years have seen big developments in our capacity to understand the nature and impact of existing disease, from imaging to pathology. We are improving our understanding of how disease in one organ increases the risk of damage to others. With the advances currently underway in genomic testing, we may be able to predict future disease rather than simply understand present illness.[43] Advances in neurosciences are telling us more about the importance of pregnancy and early childhood for subsequent health and wellbeing.[44] Our understanding of the wider determinants of physical and

39 2006 Commonwealth Fund international Health Policy Survey of Primary Care Physicians.

40 This is based on the impact of depression of Disability Adjusted Life Years (DALYs). C. Mathers and D. Loncar, Projections of Global Mortality and Burden from Disease 2002 to 2030, *PLoS Med* 3(11): e442.

41 *Our health, our care, our say,* HM Government, January 2006.

42 Department of Health, *Raising the Profile of long-term Conditions: A Compendium of Information*, January 2008.

43 K Philips et al, "Genetic testing and pharmacogenomics: issues for determining the impact to healthcare delivery and costs," *Am J of Managed Care*, 2004 Jul; 10(7): 425-432.

44 Center on the Developing Child at Harvard University (2007) *A Science-based framework for early childhood policy: using evidence to improve outcomes in learning, behaviour and health for vulnerable children* Cambridge, MA.

mental health and their impact and interactions is improving all the time. All of this presents the NHS with an unprecedented opportunity to move from reactive diagnosis and treatment to be able to proactively predict and prevent ill health.

19. Improved technology is enabling patients that would once have been hospitalised to live fulfilling lives in the community, supported by their family doctor and multi-professional community teams. Where patients were once confined to hospital, Wireless and Bluetooth technologies allow their health to be monitored in their own homes. For instance, a thousand people in Cornwall are having simple-to-use biometric equipment installed in their own homes, enabling them to monitor their own blood pressure, blood sugar and blood oxygen levels.[45] This information helps to prevent unnecessary hospital admissions. This is better for patients and their carers, delivers improved outcomes, and is a very efficient way of using NHS resources. An even bigger factor in the shift from hospital to home is the up-skilling of a wider range of staff, and the removal of barriers to more independent working in the patient's interest.

20. We continue to develop pioneering treatments for diseases. For the same illness, open surgery leaves patients in hospital for several weeks where keyhole surgery enables them to go home in just a few days. With advances in robotics, patients can look forward to scar-free surgery.[46] A major expansion in our ability to offer psychological therapies for depression and anxiety will mean that many people who were previously untreated will in future receive treatment based on the best international evidence.

21. Healthcare itself is on a journey where the emphasis of care is shifting to extending wellness and improving health. This is making healthcare more complex, with a broader range of interventions possible. In some areas of practice, such as for acute coronary syndrome, this has led to increased standardisation where the evidence shows that following protocols leads to better outcomes.[47] In others, such as the treatment of paediatric cancers, innovations mean that best practice is constantly changing and evolving.[48] For patients, these medical advances often mean longer and more fulfilling lives. There are, however, broader implications. Greater clinical uncertainty requires both greater professional judgement as to what is the right course of action for an individual patient and a more open and honest discussion of risks to enable patients to make informed decisions.

45 Cornwall is one of the Whole System Demonstrator sites promised on page 120 of the *Our health, our care*, our say White Paper.

46 For more information see Darzi, *Saws and Scalpels to Lasers and Robots – Advances in Surgery* (2007).

47 SA Spinler, "Managing acute coronary syndrome: evidence-based approaches," *Am J Health Syst Pharm*, 2007 Jun 1;64(11 Suppl 7):S14-24.

48 P. Paolucci, "Challenges in prescribing drugs for children with cancer," *Lancet Oncol.*, 2008 Feb;9(2):176-83.

2

Challenge 6: A changing health workplace

22. In recent years, Britain has become a 'knowledge economy' with the majority of new jobs being in knowledge-based industries.[49] Healthcare has always been a knowledge-led sector, relying on expert learning and depth of experience. Increasing complexity is an integral feature of modern healthcare. With new advances in clinical science and new treatments for patients, come fresh challenges for professionals. Whether in acute or community settings, easy and convenient access to knowledge is an essential part of a modern and effective workplace.

23. Expectations of work in healthcare are changing, with people today seeking *quality work*.[50] Healthcare professionals expect the depth of their expertise to be recognised and rewarded, and their skills to be developed and enhanced. They seek personal fulfilment as well as financial reward.[51] They understand the demands of accountability and welcome transparency as a route to achieving true meritocracy. Staff expect a better work/life balance and more respect and regard for pressures on their time beyond those of their profession.

24. High quality work is not simply a matter of a good deal for staff and for patients. It is also essential to meeting the productivity challenge: high quality workplaces make best use of the talents of their people, ensuring that their skills are up to date, and their efforts never wasted. The public rightly expect their taxes to be put to best use. For those working in the NHS there is a need to reduce unnecessary bureaucracy, freeing up their time to care for patients, within the resources available. Creating high quality workplaces requires great leadership and good management.

Where we stand today

25. I believe we are well placed to respond to these challenges not only because of the progress made over recent years but also because of the fundamental basis of our NHS as a tax-funded system, based on clinical need rather than ability to pay. In this respect, the NHS is unlike health systems in comparable countries, and is particularly well positioned to respond.

26. For insurance companies, there is no incentive to invest in the prevention of ill health as patients may move to a different scheme. Diagnostics increase the capacity of the NHS to reach out to predict and prevent ill health, but in other systems they increase their capacity to exclude those at risk from the protection they need.

49 Ian Brinkley, *The Knowledge Economy: How Knowledge is Reshaping the Economic Life of Nations*, March 2008, The Work Foundation.

50 For more on the importance of work quality see G. Lowe, *The Quality of Work: A People-Centred Agenda*, 2000.

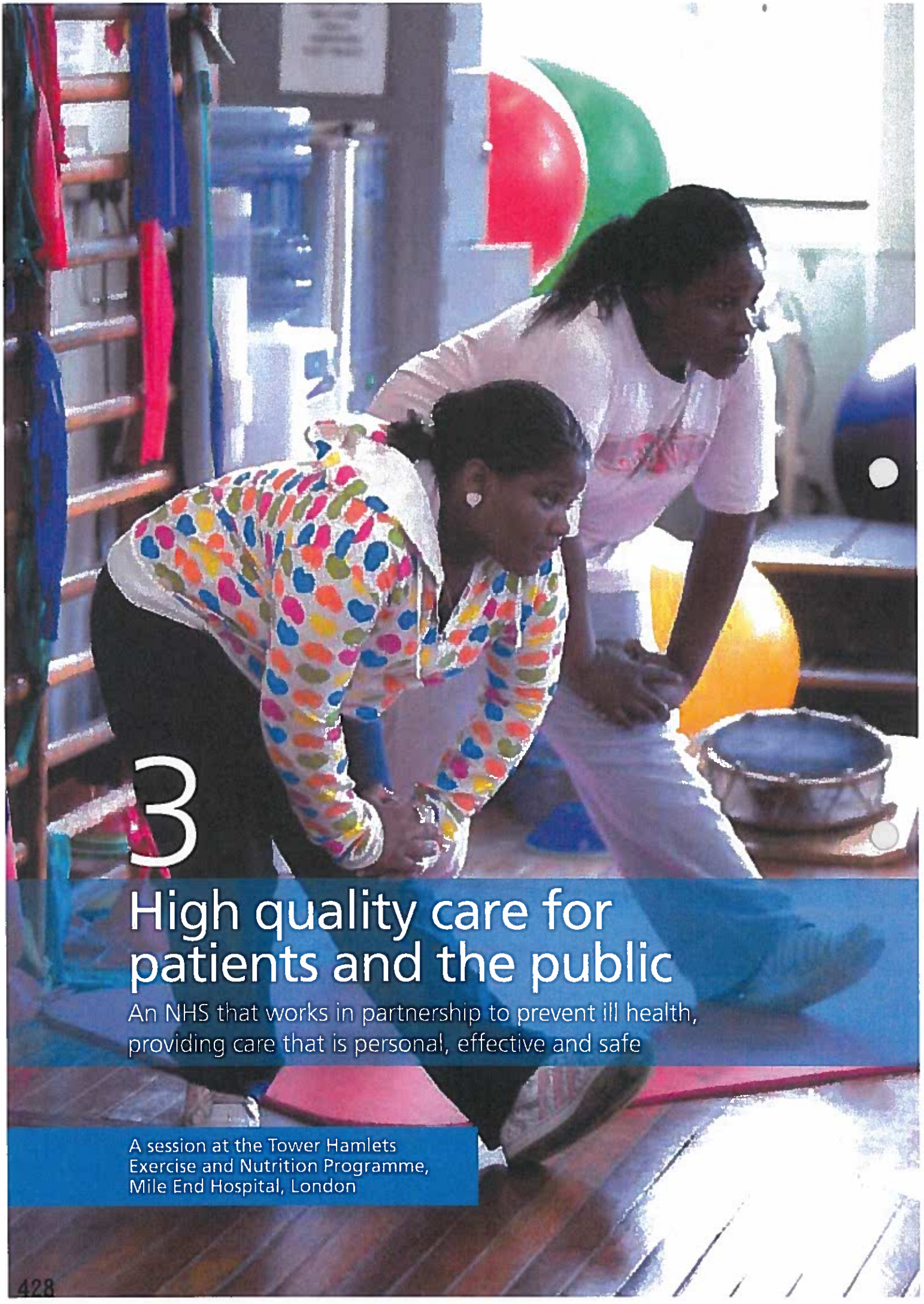
51 On doctor's motivation see S. Dewar et al., *Understanding Doctors' Harnessing Professionalism*, King's Fund, May 2008.

27. The Wanless Report of 2002 made the case for additional investment in the NHS, to which the Government has responded.[52] The NHS is now funded at close to the EU average.[53] In 2009/10, the NHS budget will exceed £100 billion. The NHS has the financial resources it needs.

28. However, the NHS must use these resources well. Increasing expectations, an ageing population, a rise in lifestyle disease and the cost of new treatments will all impose greater costs.

29. The NHS must respond by improving the quality of care it provides. This is because the evidence shows that, in general, higher quality care works out better for patients and the taxpayer. For instance, day surgery for cataracts delivers the highest quality of care with no admission to hospital.[54] High quality care is safe, meaning no avoidable healthcare associated infections. This is obviously better for patients and also reduces the need for costly post-infection recovery in hospital. Finally, high quality care involves giving the patient more control over their care, including information to make healthy choices, which will reduce their chances of poor health and dependency on the NHS. The answer to the challenges the NHS faces is therefore to focus on improving the quality of care it provides.

52 Wanless, *Securing our Future Health* (2002).
53 In 2008 the UK is expected to spend 9.0% of its GDP on health, compared with an average of 9.5% amongst the 15 pre-enlargement EU members.
54 Cataract extraction was one of a "basket" of 25 procedures recommended by the Audit Commission in 2001 as suitable for day surgery. Day surgery for cataract removal is less than two thirds of the cost of doing it as an inpatient procedure (RCI 2005).



3

High quality care for patients and the public

An NHS that works in partnership to prevent ill health, providing care that is personal, effective and safe

A session at the Tower Hamlets Exercise and Nutrition Programme, Mile End Hospital, London

3

High quality care for patients and the public

An NHS that works in partnership to prevent ill health, providing care that is personal, effective and safe

Introduction

1. This Review is about achieving the highest quality of care for patients and the public. I have heard from patients and staff, and I know from my own experience, that when in the care of the NHS, it is the quality of that care that really matters. People want to know they will receive effective treatment. They want care that is personal to them, and to be shown compassion, dignity and respect by those caring for them. People want to be reassured that they will be safe in the care of the NHS. And whilst most people recognise their health is their responsibility, they also look to the NHS for help.

2. The investment and reform of the past decade have given us the opportunity to pursue this ambitious agenda for patients and the public.

3. Ten years ago, today's quality reform agenda would have seemed particularly challenging. The extra capacity in the NHS today gives all of us the opportunity to focus on improving quality. To achieve that we need to:

   - **Help people to stay healthy**. The NHS needs to work with its national and local partners more effectively, making a stronger contribution to promoting health, and ensuring easier access to prevention services.

   - **Empower patients**. The NHS needs to give patients more rights and control over their own health and care, for more personal care.

   - **Provide the most effective treatments**. Patients need improved access to the treatments they need supported by improved diagnostics to detect disease earlier.

   - **Keep patients as safe as possible**. The NHS must strive to be the safest health system, keeping patients in environments that are clean, and reducing avoidable harm.

Helping people to stay healthy

4. Our health starts with what we do for ourselves and our families, but the environment we live in influences our decisions and ultimately our health. Some people live in circumstances that make it harder to choose healthy lifestyles. Changing this environment can influence the way people look after their own and their families' health. This is particularly important if we are to tackle inequalities in health status and outcomes.

3

5. Patients and the public want the NHS to play its part in helping them to stay healthy. Nearly a quarter of people felt health was 'mainly my' responsibility, and a further 60 per cent felt it was 'mainly me with support from the NHS.'[55] Alongside the NHS, we need to ensure that a range of organisations – public and private – play their part in supporting people to stay healthy.

6. Locally, the NHS and local authorities are working closely together to improve health and wellbeing, prompted by their legal duty to co-operate in improving outcomes for their populations. The duty is based on a formal assessment of people's needs (Joint Strategic Needs Assessments) developed between primary care trusts, local authorities and other local partners, including police authorities and local hospitals, to tackle the most important factors in improving health. These plans focus not only on tackling clear health priorities such as smoking, childhood obesity and teenage pregnancy, but also on broader factors such as poor housing, education, local transport and recreational facilities.

Focusing on helping prevent ill health

7. As well as improving partnership working, the NHS itself has strengthened its contribution to preventing ill health through sustained investment over the past decade. As the visions show, the foundations of good health and healthy lifestyles are laid down in the very earliest stages of life. The Child and Young People's Health Strategy due in the autumn will seek to build on the new Child Health Promotion Programme that sees highly skilled health visitors and school nurses supporting families on health and parenting from pregnancy onwards. It will also bring with it a further focus on improving services for adolescents.[56]

8. Progress has been made in detecting illnesses earlier and preventing them from worsening, including in cardiac and cancer services. Much of this progress has been achieved through national screening and immunisation programmes. We need to continue this progress.

9. We will therefore strive to accept and implement every recommendation for screening and vaccination programmes that the relevant national expert committees make.[57] This will be a pledge within the NHS Constitution so that people know these services will be available without question, where they are clinically and cost effective.

55 Primary and Community Care Deliberative Event, run by HCHV, April 2008.

56 *The Children's Plan*, published in December 2007 by the Department for Children, Families and Schools (DCFS) committed to DCFS and the Department of Health publishing a joint child health strategy

57 These are the Joint Committee on Vaccination and Immunisation (JCVI) and the National Screening Committee (NSC).

10. There remains significant room for improvement, especially across the risk factors identified in chapter two – disease, smoking, excessive drinking, poor diet and lack of exercise. The NHS must now focus on preventing ill health for individuals and giving them the opportunities and support to improve their health.

11. Vascular conditions are major causes of early death, long-term illness and health inequality. These include coronary heart disease, stroke, diabetes and kidney disease. Taken together, they affect over 4.5 million people in England, and are responsible for over 170,000 deaths every year.[58] Some of these deaths could be prevented if people understood their own health status. Where people can act to decrease their chance of developing particular forms of ill health, we want people to understand clearly what the risks are to their health and what they can do to prevent the onset of irreversible disease.

12. Earlier this year we announced help for people to do this through vascular health checks for everyone aged 40-74.[59] These will be introduced from 2009, and rolled out through GPs, pharmacies and community clinics. By 2012, we expect three million people every year to be offered a check, preventing at least 9,500 heart attacks and strokes and 4,000 people from developing diabetes each year. We will make it easy and convenient to access these checks in a variety of places. In particular, we believe that pharmacies have a key role to play as providers of prevention services.[60]

13. We need to raise awareness of this new service. We will do this through a nationwide 'Reduce Your Risk' campaign, which will be launched during 2009 alongside vascular health checks. This campaign will clearly explain what people can do to reduce their risks: stop smoking, maintain a healthy weight, increase physical activity, lower blood pressure. We will also work with third sector groups to reach those less likely to access services.

Ensuring that people have convenient access to prevention services

14. Working with their local partners, every primary care trust will commission comprehensive wellbeing and prevention services, with the services offered customised to meet the specific needs of their local populations. This reflects the finding of the SHA staying healthy groups, who called for prevention services on "an industrial scale." Our efforts must be focused on six key goals: tackling obesity, reducing alcohol harm, treating drug addiction, reducing smoking rates, improving

58 See Department of Health, *Putting Prevention First*, April 2008.

59 For more information on the rationale for the age range of 40-74 see Department of Health, *Technical consultation on economic modelling of a policy of vascular checks*, June 2008

60 Department of Health, *Pharmacy in England: building on strengths – delivering the future*, April 2008.

3

sexual health and improving mental health. Examples of services that we expect local PCTs to develop and expand include alcohol brief interventions, exercise referral, weight management and talking therapies, and we expect the reach of these services to increase as the NHS seeks to support all of us in making healthier choices.

15. Reflecting this new priority for the NHS, and the need to work together with partners from all sectors of society, we will launch shortly a Coalition for Better Health. The Coalition will be a new set of voluntary agreements between government, private and third sector organisations, focused on the action each needs to take to achieve better health outcomes for the nation. As we announced in *Healthy Weight, Healthy Lives* earlier this year, its initial priority will be combatting obesity by supporting healthier food, more physical activity, and encouraging employers to invest more in the health of their employees.[61]

16. All too often, those living in poverty are poorest in health.[62] As set out in the recent Health Inequalities strategy, the root causes of ill health lie heavily in people's life circumstances.[63] Excellent prevention services are a matter of fairness, and primary and community services have a pivotal role to play in reaching out to those communities where socio-economic factors are linked to reduced life expectancy and higher prevalence of illness.

17. In my Interim Report, I set out plans to tackle inequalities in primary care by establishing over 100 new GP practices in the areas of the country with the fewest primary care clinicians and the greatest health needs – more often than not, these are our most deprived communities.

18. To improve access to primary care services, my interim report also announced that we would invest additional resources to enable the local NHS to develop over 150 GP-led health centres to supplement existing services. The services provided in these centres will reflect local needs and priorities. Primary care trusts will ensure that these centres are open at more convenient hours that fit with people's lifestyles (8am to 8pm every day) and that they are open to any member of the public, so that people can walk in regardless of which local GP service they are registered with. People will be offered the opportunity to register at these new facilities, should they choose.

19. These health centres will provide additional, convenient access to primary care services, including in the evenings and at weekends. PCTs have been developing proposals locally not only for additional access to GP services, but also to a much

61 *Healthy Weight, Healthy Lives*, HM Government, May 2008.
62 See for instance M. Marmot, "The Social Determinants of Health Inequalities," *Lancet* 2005, 365, 1099-1104.
63 Department of Health, *Health Inequalities. Progress and Next Steps*, June 2008.

broader range of services such as diagnostic, mental health, sexual health, social care and healthy living services to match the needs of their communities. This broader range of services will not inhibit any patient's continuity of care. It is precisely because these needs vary that there is no national blueprint.

20. *NHS Next Stage Review: Our Vision for Primary and Community Care* will be published shortly. The main features of that strategy are summarised in this report. NHS primary and community care services are strongly rooted in their local communities and patients, carers and their families rightly value the personal relationships and continuity of care that they provide. The strategy will describe a vision for primary and community care that builds on these strengths and raises our ambitions. It will focus on making services personal and responsive to all, promoting healthy lives and striving to improve the quality of care provided.

21. Currently the incentives for General Practice focus largely on the effective management of long-term conditions rather than seeking to prevent those conditions in the first place. We will change this by supporting family doctors to play a wider role in helping individuals and their families to stay healthy. We will work with professional and patient groups to improve the world-leading Quality and Outcomes Framework to provide better incentives for maintaining good health as well as good care. Family doctors, practice nurses and other primary and community clinicians will have greater opportunities and incentives to advise people on measures they can take to improve their health. We will support this by investing new resources in the areas that are worst affected by obesity and alcohol-related ill health.

22. For many people, one of the most convenient places to access preventive services is at their place of work. Evidence shows that employers can make a very positive contribution to the health of their employees, and that where they invest in employee health they very often reap benefits in employee motivation, in productivity and in profit too.[64] To encourage this investment, we are working in partnership with the Department for Work and Pensions and Business in the Community to ensure that 75 per cent of FTSE 100 companies report on their employee's health and wellbeing at board level by 2011.

23. Preventing ill health often also means helping people stay in employment. A recent review of the health of the working age population underlined the benefits of work and employment for our

64 Wang PS et al., "The costs and benefits of enhanced depression care to employers," *Arch Gen Psychiatry*. 2006 Dec;63(12) found that both employees and employers would benefit if employers improved access to mental health services for their employees

3

overall health and well-being.[65] It highlighted the rapidly rising risks to long-term health if people are not supported sufficiently early to address issues that stop them from working, with back problems and mental ill health among the most significant. From next year, we will introduce integrated Fit for Work services in primary and community care, bringing together access to musculoskeletal services and psychological therapies for example. This will help people get the support they need to return to appropriate work faster.

Empowering patients: more rights and control over health and care

24. Over the last decade, the NHS has gradually given patients more control over their own care. People referred for secondary or hospital-based care can now choose freely where they receive their treatment. And increasingly, there is better information available for patients about outcomes of care such as the information at GP-practice level from the Quality and Outcomes Framework.

25. Patients empowered in this way are more likely to take greater responsibility for their own health, and to dedicate their own time, effort and energy to solving their health problems. This partnership is especially important for those with long-term conditions and their carers. We must therefore continue to empower patients with greater choice, better information, and more control and influence.

Greater choice

26. Today, people who need to be referred for secondary care have free choice of any hospital or treatment centre – NHS or independent sector – that can provide NHS quality care at the NHS price. Choice gives patients the power they need in the system, as NHS resources follows patients in the choices they make. Where patients find it difficult to express preferences, it is the role of staff to take steps to ensure that patients can benefit from greater choice. Choice in public services is sometimes presented as the pre-occupation of the wealthy and the educated, yet the evidence shows that it is the poorest and least well educated who most desire greater choice.[66] We believe that choice should become a defining feature of the service. A health service without freedom of choice is not personalised. So the right to choice will now be part of the NHS Constitution, ensuring that people become more clearly aware of it.

65 Dame Carol Black, *Working for a Healthier Tomorrow*, Crown Copyright, March 2008.

66 The British Social Attitudes survey found that 67% of semi-routine and routine workers want more choice compared to 59% of managerial and professional workers, and 69% of people with no formal educational qualifications want more choice compared to 55% of those with higher educational qualifications. Appleby & Alvarez, *British Social Attitudes Survey 22nd Report, Public Responses to NHS Reform*, 2005.

27. It is because we believe that choice has given more control to patients and helped to develop services that respond to their expectations, that we will now put a stronger focus on extending choice in primary and community care. In 1948, the Government informed members of the public that they had a choice of GP.[67] People can indeed choose which GP practice to register with, but in some areas the degree of choice is still restricted by closed patient lists, by practices saying they are 'open but full', or by narrow practice boundaries. We will support the local NHS, working with GPs, to give the public a greater and more informed choice, not just for GP services but for the wider range of community health services.

28. Providing greater choice of GP will mean developing fairer rewards for practices that provide responsive services and attract more patients. At present, most GP practices receive historic income guarantees that do not necessarily bear relation to the size or needs of the patient population they now serve, or the number of patients they see. We will work with GP representatives to manage the phase out of these protected income payments, so that more resources can go into providing fair payments based on the needs of the local population served by each practice.

67 *The New National Health Service*, Central Office of Information for the Ministry of Health, Crown Copyright (1948).

Better information

29. We want patients to make the right choices for themselves and their families. So we will empower them to make *informed* choices. The first step towards this vision was taken with the launch of the NHS Choices website, with a variety of limited quality information (such as Healthcare Commission ratings and MRSA rates at an organisation level).[68] The next stage is to empower patients with clear information on the quality of each service offered by every NHS organisation – across all settings of care.

30. In practice, this means easy-to-understand, service-specific, comparable information available online. The information will be on every aspect of high quality care – on safety such as cleanliness and infection rates, on experiences such as satisfaction, dignity and respect, and on measures of outcomes that include patients' views on the success of treatments. *Chapter 4* sets out in more detail how we will do this. And the NHS Constitution will guarantee that this information on quality will be freely and openly available as well as reliable.

31. In primary care, we will continue to develop the NHS Choices website to include more comparative information about the range of services offered by GP practices, their opening times, the views of local patients, and their performance

68 NHS Choices can be found at www.nhs.uk

3

against key quality indicators. We will also develop the website so that it offers a simpler way of registering electronically with a GP practice. These national efforts to improve choice of GP should be mirrored at local level, for instance through local NHS information packs for people who have just moved house.

32. During the Review, patients have told us that they need better information and more help to understand how to access the best care, especially urgent care, when they need it. I said in my interim report that we should consider options to introduce a new three-digit telephone number to help people find the right local service to meet their urgent, unplanned care needs. Several of the visions included plans to develop such a number.[69] We will learn from this local work as we consider nationally the costs and benefits of an urgent care member. We will set out further details from this next phase of work later this year.

Increased control

33. We have to keep up with the expectations of the public. This will mean allowing people to exercise choice and be partners in decisions about their own care, shaping and directing it with high quality information and support. Empowering patients in this way enables them to use their personal knowledge, time and energy for solving their own health problems. The fundamental solution to the rise of lifestyle diseases is to change our lifestyles. While the NHS can support and encourage change, ultimately, these are decisions that can only be made by us as individuals. Those with two or more long-term conditions are more likely to be obese, eat less healthily and smoke than those with one or none.[70] People need to know the risks and have the opportunity to take control of their own healthcare. To help with this, the Department of Health will publish a new Patients' Prospectus by the end of this year to provide patients with long-term conditions the information they need about the choices which should be available to them locally and to enable them to self-care in partnership with health and social care professionals.

34. Beyond this, international best practice suggests that control by a patient is best achieved through the agreement of a personal care plan. In Germany, nearly two-thirds of people with long-term conditions have a personal care plan, whereas the same is true for only a fifth of people in this country.[71] Care planning creates packages of care that are personal to the patient. It involves working with professionals who really understand their needs, to agree goals, the services chosen, and how and where to access them. Personal care plans

69 See for instance the NHS East Midlands and NHS London visions.

70 Department of Health, *Long term conditions Compendium of Information*, January 2008.

71 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.

are agreed by the individual and a lead professional.[72]

35. Over the next two years, every one of the 15 million people with one or more long-term conditions should be offered a personalised care plan, developed, agreed and regularly reviewed with a named lead professional from among the team of staff who help manage their care. The lead professional takes a lead within the care team for advising the patient on how best to access the care that the plan sets out. For people with a serious mental illness, the 'care programme approach' (CPA) has pioneered this approach.[73] Primary care trusts and local authorities have the responsibility to ensure that all this is achieved, as well as offering a choice of treatment setting and provider.

36. Increased control will not be limited to those being cared for, but will also extend to carers. A new strategy has been published, setting out the Government's plans for supporting carers.[74]

37. Achieving the strong partnership that characterises personalised care is only possible through greater 'health literacy'. Too few people have access to information about their care or their own care record. We will change this. We will expand the educational role of the NHS Choices website. We will introduce HealthSpace online from next year, enabling increasing numbers of patients to securely see and suggest corrections to a summary of their care records, to receive personalised information about staying healthy, and to upload the results of health checks for their clinician(s) to see.[75]

38. All patients will have a right to see the information held about them, including diagnostic tests. We will ensure that patients' right to access their own health records is clear by making this part of the NHS Constitution.

Greater influence over resources

39. We will increase the influence that patients have over NHS resources. For hospitals, resources already follow the choices that patients make through the Payment by Results system.[76] We will strengthen this by reflecting quality in the payment mechanism and increasing individual control.

40. First, we will make payments to hospitals conditional on the quality of care given to patients as well as the volume. A range of quality measures covering safety (including cleanliness and infection rates), clinical outcomes, patient experience

72 This more personalised and joint approach extends the original commitment to care plans in the *Our health, our care*, our say White Paper.

73 Department of Health, *Refocusing the Care Programme Approach*, March 2008.

74 Department of Health, *Carers at the heart of 21st century families and communities*, June 2008.

75 Further details on our plans for information are addressed in the Health Information Review, which will be published shortly.

76 In 2008/09, over 60 per cent of the average hospital's income is through Payment by Results.

3

and patient's views about the success of their treatment (known as patient-reported outcome measures or PROMs) will be used.[77]

41. This 'Commissioning for Quality & Innovation' (CQUIN) scheme will encourage all NHS organisations to pay a higher regard to quality. The scheme will build upon best practice found in the NHS and internationally.[78] It will be a simple overlay to the Payment by Results system, forming part of commissioning contracts. Funding will be freed up through reducing the tariff uplift from 2009 to give commissioners dedicated space to pay for improved outcomes. Providers will be rewarded in the first year for submitting data. From no later than 2010, payments will reward outcomes under the scheme. The scheme will be flexible to suit local circumstances. Where PCTs want to go faster, they will be able to apply the principles as soon as they wish. The scheme will be subject to independent evaluation so that it improves as it matures.

42. Second, we will go even further in empowering individual patients. Learning from the experience in both social care and other health systems, and in response to the enthusiasm we have heard from local clinicians, we will explore the potential of personal budgets, to give individual patients greater control over the services they receive and the providers from which they receive services.[79] Personal health budgets are likely to work for patients with fairly stable and predictable conditions, well placed to make informed choices about their treatment; for example, some of those in receipt of continuing care or with long-term conditions. With a view to national roll out, we will launch a national pilot programme in early 2009, supported by rigorous evaluation. This will enable the NHS and their local authority partners to test out a range of different models.

43. The budget itself may well be held on the patient's behalf, but we will pilot direct payments where this makes most sense for particular patients in certain circumstances. We will legislate to enable these direct payments.

44. The programme will be designed with NHS, local authority, carer and patient group partners, with clear rules. We will ensure that the programme fully supports the principles of the NHS as a comprehensive service, free at the point of use. It will be voluntary – no one will ever be forced to have a budget, and for those that choose to, there will be tailored support

77 Department of Health, *The NHS in England: Operating Framework 2008/9*, December 2007.
78 NHS North West have introduced a scheme to pay for performance.
79 Members of NHS Yorkshire and Humber area's clinical working group on long term conditions advocated exploring personal budgets in healthcare.

to meet their different needs. The programme will be underpinned by safeguards so that no one will ever be denied treatment as a result of having a personal budget, and NHS resources will be put to good use, with appropriate accountability.

Partnership focused on people

45. Partnership working between the NHS, local authorities and social care partners will help to improve people's health and wellbeing, by organising services around patients, and not people around services. This will lead to a patient-centred and seamless approach. This is important not only for people regularly using primary, community and social care services, but will also help people's transition from hospitals back in to their homes. It will also reduce unnecessary re-admissions in to hospitals. In addition local NHS organisations should work in partnership with the local authority, 3rd sector and private sector organisations, patients and carers to implement the *Putting People First* transformation programme for social care.[80] This programme sets out the Government's vision for the personalisation of social care. It aims to improve people's health and wellbeing through new mechanisms such as personal budgets.

80 *Putting People First, A shared vision and commitment to the transformation of adult social care*, HM Government, December 2007

Ensuring access to the most effective treatments

46. Patients want the most effective treatments, and staff want to be able to provide them. As the NHS becomes more personal, patients and the public want to be assured that the most clinically and cost effective treatments are available everywhere. During this Review, patients and the public were very clear that they had zero tolerance for variations in access to the most effective treatments. The National Institute for Health and Clinical Excellence (NICE), established in 1999, has developed a worldwide reputation for its work in evaluating health interventions. It has highly regarded, transparent processes for assessing new, licensed drugs and medical technologies to determine clinical and cost effectiveness.

47. It has sometimes taken too long for NICE appraisal guidance to be made available on newly licensed drugs. Guidance has often been published two years or more after a new drug's launch, though NICE has now put in place a faster appraisal process for key new drugs which enables it to issue authoritative guidance on them within a few months of their UK launch. Whilst all primary care trusts have a legal duty to fund drugs that have been positively appraised by NICE, we recognise that patients and the public are concerned that there remains unexplained variation in the way local decisions are made on the funding of new drugs before the appraisal takes place, or where no guidance is issued.

3

48. We will take steps to end this so-called 'postcode lottery' for new drugs and treatments. Through the NHS Constitution we will make explicit the right of NHS patients everywhere to positively NICE-appraised drugs and treatments, where their doctor judges that these would be of benefit. The Constitution will also make clear the right of patients to expect rational local decisions on funding of new drugs and treatments. Open and honest explanation will be due if the local NHS decides not to fund a drug or treatment that patient and clinician feel would be appropriate.

49. Furthermore, we will work with NICE to enable them to produce consistently fast guidance on significant new drugs. This will be achieved by making further improvements to the topic selection and appraisal process. It will mean that NICE can issue the majority of its appraisal guidance within a few months of a new drug's launch.

50. In addition, the Secretary of State for Health has recently asked the National Cancer Director, Professor Mike Richards CBE, to review policy relating to patients who choose to pay privately for drugs not funded on the NHS. This specifically targeted review, to report later this year, will make recommendations on whether and how policy or guidance could be clarified or improved.

51. Looking to the future, we will strengthen the horizon scanning process for new medicines in development. We will involve the industry systematically to support better forward planning and to develop ways of measuring the uptake of clinically and cost effective medicines once introduced. For new clinical technologies, we will simplify the way in which they pass from development into wider use by creating a single evaluation pathway, and will develop ways to benchmark and monitor their successful uptake.

Keeping patients as safe as possible

52. Continuously improving patient safety should be at the top of the healthcare agenda for the 21st century. The injunction to 'do no harm' is one of the defining principles of the clinical professions, and as my Interim Report made clear, safety must be paramount for the NHS. Public trust in the NHS is conditional on our ability to keep patients safe when they are in our care.

53. In recent years, with additional investment, the NHS has focused on raising levels of cleanliness and reducing rates of healthcare associated infections, including through the measures set out in my Interim Report.[81] Today, rates of MRSA and *C. difficile* are falling – but we must continue to combat healthcare associated infections.[82] For that reason, we have recently announced a tough but fair regime

81 Darzi, *Our NHS, Our Future: Interim Report*, October 2007.

82 For more information see the DH publication *The Quarter: Quarter 4* 2007-08.

that robustly deals with any failures of safety.[83] Furthermore, the new health and adult social care regulator, the Care Quality Commission (CQC), will be able to use its new enforcement powers in relation to infections from April 2009.[84] This is a full year before the new powers will be available to it in relation to other quality and safety requirements.

54. Infections are only one area where action is needed. Since 2003, we have made great progress on the reporting of safety incidents. The National Reporting and Learning System (NRLS) has received two million reports of adverse incidents ranging from the very minor to the extremely serious. Safety incidents can involve a wide array of factors, from infrastructure, training, treatment protocols, procedure and communication to simple administrative errors. Safety is the responsibility of all staff, clinical and non-clinical.

55. Building on *Safety First*,[85] the next stage is to implement systematic improvement, locally, regionally and nationally. The National Patient Safety Campaign is being launched, led by the service. From April 2009 the NPSA will run an additional, dedicated national patient safety initiative to tackle central line catheter-related bloodstream infections, drawing lessons from a remarkably successful Michigan initiative on the same topic.[86] The NPSA will run regular patient safety initiatives like this in future.

56. In some parts of the United States, events that are serious and largely preventable such as 'wrong-site' surgery have been designated 'Never Events', and payment withheld when they occur. The NPSA will work with stakeholders in this country to draw up its own list of 'Never Events'. From next year, PCTs will choose priorities from this list in their annual operating plan.

Conclusion

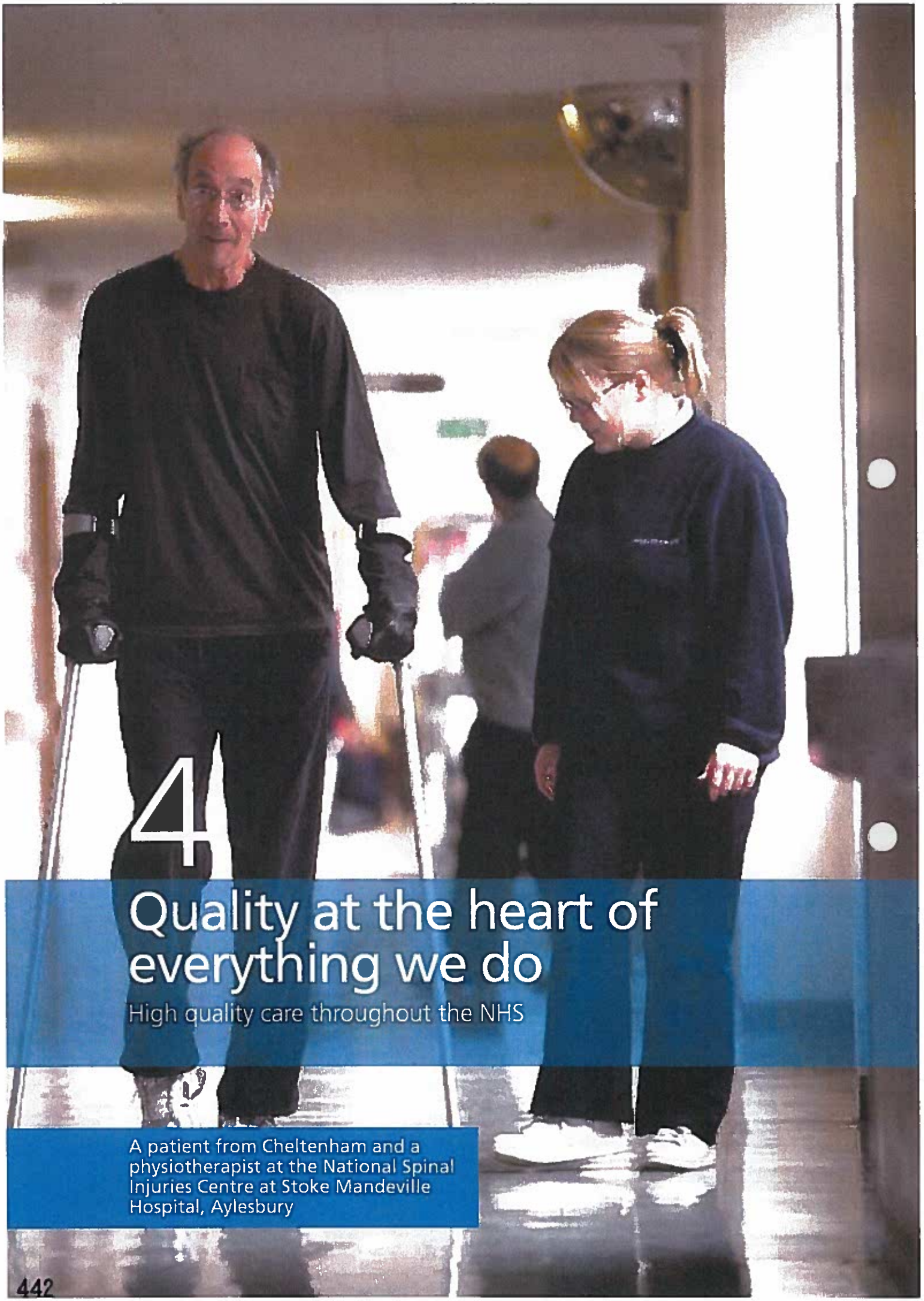
57. High quality care is care where patients are in control, have effective access to treatment, are safe and where illnesses are not just treated, but prevented. These are manifestations of high quality care – there is much more to be done to place quality right at the heart of the NHS.

83 Department of Health, *Developing the NHS Performance Regime*, June 2008.

84 Subject to the Parliamentary passage of the current Health and Social Care Bill.

85 *Safety First, A report for patients, clinicians and healthcare managers*, Department of Health, December 2006.

86 Hales BM, Pronovost PJ, The checklist – a tool for error management and performance improvement. *J Crit Care* 2006;21(3):231-5 and Berenholtz SM, Pronovost PJ, Lipsett PA, et al. Eliminating catheter-related bloodstream infections in the intensive care unit. *Crit Care Med* 2004;32(10):2014-20.



4

Quality at the heart of everything we do

High quality care throughout the NHS

A patient from Cheltenham and a physiotherapist at the National Spinal Injuries Centre at Stoke Mandeville Hospital, Aylesbury

4

Quality at the heart of everything we do

High quality care throughout the NHS

Introduction

1. Having considered what high quality care looks like for patients and the public, we need to think how it becomes integral to the NHS. My Interim Report contained the message that the NHS has an unprecedented opportunity to focus on quality and that this opportunity should be seized.[87] The vision documents show the enthusiasm of frontline clinicians to take up the quality challenge.

2. If quality is to be at the heart of everything we do, it must be understood from the perspective of patients. Patients pay regard both to clinical outcomes and their experience of the service. They understand that not all treatments are perfect, but they do not accept that the organisation of their care should put them at risk. For these reasons, the Review has found that for the NHS, quality should include the following aspects:[88]

   - **Patient safety**. The first dimension of quality must be that we do no harm to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections.

   - **Patient experience**. Quality of care includes quality of *caring*. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences.

   - **Effectiveness of care**. This means understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Just as important is the effectiveness of care from the patient's own perspective which will be measured through patient-reported outcomes measures (PROMs). Examples include improvement in pain-free movement after a joint replacement, or returning to work after treatment for depression. Clinical effectiveness may also extend to people's well-being and ability to live independent lives.

3. Reforms have improved quality in terms of patient safety and effectiveness of care. For instance, the introduction of standards

87 Darzi, *Our NHS, Our Future. Interim Report*, October 2007

88 See Darzi, A. *Quality and the NHS Next Stage Review*, Lancet.

4

through National Service Frameworks has led to major progress on tackling illnesses such as cancer and heart disease. Conversations about quality take place in multi-disciplinary teams rather than in corridors. Independent performance assessment and regulation of providers has been introduced. The positive impact of these reforms has been noted by independent commentators such as the Nuffield Trust.[89]

4. Nevertheless, it is also true that progress has been patchy, particularly on patient experience. The local clinical visions found unacceptable and unexplained variations in the clinical quality of care in every NHS region.[90] They identified important changes that need to be made to raise standards and ensure all services are high quality. The NHS has to keep moving forward to make sure patients benefit from new treatments and technologies.

5. In my experience, providing high quality care leads to professional pride, and focusing on improving it energises and motivates all NHS staff, clinical and non-clinical alike. I believe we can use that energy and make the achievement of high quality of care an obsession within the NHS. To do this will require seven steps, building on the cornerstone of existing local clinical governance:

- **Bring clarity to quality**. This means being clear about what high quality care looks like in all specialties and reflecting this in a coherent approach to the setting of standards.

- **Measure quality**. In order to work out how to improve we need to measure and understand exactly what we do. The NHS needs a quality measurement framework at every level.

- **Publish quality performance**. Making data on how well we are doing widely available to staff, patients and the public will help us understand variation and best practice and focus on improvement.

- **Recognise and reward quality**. The system should recognise and reward improvement in the quality of care and service. This means ensuring that the right incentives are in place to support quality improvement.

- **Raise standards**. Quality is improved by empowered patients and empowered professionals. There must be a stronger role for clinical leadership and management throughout the NHS.

- **Safeguard quality**. Patients and the public need to be reassured that the NHS everywhere is providing high quality care. Regulation – of professions and

89 S. Leatherman and K. Sutherland, *The Quest for Quality: Refining the NHS Reforms*, Nuffield Trust, May 2008.

90 See for instance NHS East of England, *Towards the best, together*, May 2008, which notes the huge variation in caesarean section rates between hospitals (from 15% to 27%) and the big variation in consultant level psychology staff across the region.

of services – has a key role to play in ensuring this is the case.

- **Stay ahead**. New treatments are constantly redefining what high quality care looks like. We must support innovation to foster a pioneering NHS.

Bringing clarity to quality

6. We will begin by changing the way standards are set, to bring greater clarity to what high quality care looks like. For everyone working in healthcare, keeping up with best practice is a challenging task. The current breadth and depth of guidance is impressive but also daunting. National Service Frameworks have proved effective, but sometimes at the expense of securing improvement more widely across all areas of care and the spectrum of clinical conditions. Many bodies undertake standard setting, and what is desirable versus what is mandatory is often too hard to understand. In addition, NHS staff tell us that the knowledge and information they need to deliver excellent care can be too hard to find.

7. We will address these problems by transforming the role of NICE, building on its successes and internationally acclaimed reputation. From 2009, it will expand the number and reach of national quality standards, either by selecting the best available standards (including the adoption of the relevant parts of National Service Frameworks) or by filling in gaps. NICE will manage the synthesis and spread of knowledge through NHS Evidence – a new, single portal, through which anyone will be able to access clinical and non-clinical evidence and best practice, both what high quality care looks like and how to deliver it. Greater clarity on standards, and where to go to find them, will support the commissioning and uptake of the most clinically and cost effective diagnostics, treatments and procedures.

8. NICE will continue to work openly and collaboratively in partnership at national level and with frontline staff. For frontline clinicians, working with NICE is already considered a valuable opportunity for clinical professional development. In the next stage of its development, I would like to see NICE reach out even more proactively to local clinical communities as well as national ones. A key enabler of this will the establishment of a fellowship programme. I hope that many of the 2,000 frontline clinicians that led this Review locally will apply for fellowship, and that many others will come forward too.

Measuring quality

9. The next stage in achieving high quality care, requires us to unlock local innovation and improvement of quality through information – information which shows clinical teams where they most need to improve, and which enables them to track the effect of changes they implement. After all, we can only be sure to improve what we can actually measure.

10. It is important that we have a national quality framework that enables us to publish comparable

4

information on key measures. With the help and support of frontline clinicians, we have begun to identify comparable measures that are currently used by different parts of the service today, and will bring them together into an integrated national set. These national metrics will be developed through discussion with patients, the public and staff. We will announce the first set of quality indicators that will be used nationally by December 2008. And although we will begin with acute services, from next year, we will also develop and pilot a quality framework for community services.

11. The national metrics will be important, but it will be critical that local NHS organisations should sign up to the concept of quality metrics and feel motivated to augment the national indicators with their own measurements of quality. Our aim is for NHS organisations to freely develop the measures that will best help them to review the quality of the services they offer regularly.

12. Within organisations, we know that a defining characteristic of high performing teams is their willingness to measure their performance and use the information to make continuous improvements. We want all clinical teams to follow this best practice and so we will support them by working in partnership with the professional bodies, specialist societies and universities to develop a wider range of useful local metrics, than the national framework. We will also develop 'Clinical Dashboards' which will present selected national and locally developed measures in a simple graphical format as a tool to inform the daily decisions that drive quality improvement.

13. Dashboards are being piloted by frontline NHS staff in three locations:

    - In an East London A&E department, the dashboard presents information, updated every 15 minutes, about how soon patients are seen, assessed and get results from tests, and about patient satisfaction. The dashboard is used by staff and is displayed prominently in the patients' waiting area.

    - In Nottingham, a urology surgical team is using the dashboard to present information on length of stay, complications and average operation length.

    - In Bolton, a GP practice is working with the local A&E to collect and display information on the number of patients attending A&E and out-of-hours services.

14. Our goal is that every provider of NHS services should systematically measure, analyse and improve quality. They will need to develop their own quality frameworks, combining relevant indicators defined nationally, with those appropriate to local circumstances. This will include quality measures that reflect the visions for improved services that are at the core of this Review.

15. In primary care, the Quality and Outcomes Framework already provides a range of valuable data on quality, particularly for the quality of care for people with long-term conditions. *Chapter 3* set out how we will ensure GP practices will have incentives and opportunities to engage in prevention activity. We will introduce a new strategy for developing the Quality and Outcomes Framework, which will include an independent and transparent process for developing and reviewing indicators. We will discuss with NICE and with stakeholders including patient groups and professional bodies how this new process should work. We will discuss how to reduce the number of organisational or process indicators, and refocus resources on new indicators of prevention and clinical effectiveness. We will explore the scope to give greater flexibility to PCTs to work with primary healthcare teams to select quality indicators (from a national menu) that reflect local health improvement priorities.

Publishing quality performance

16. Commitments have been made over a number of years to publish information on clinical effectiveness.[91] Too often these commitments have been held up by uncertainties about what was needed to make progress and disagreements about who should be in charge. This is unacceptable. We should be seeking to create a more transparent NHS. It may be a complex task, but we should develop acceptable methodologies and then collect and publish information so that patients and their carers can make better informed choices, clinical teams can benchmark, compare and improve their performance and commissioners and providers can agree priorities for improvement.

17. Therefore, to help make quality information available, we will require, in legislation, healthcare providers working for or on behalf of the NHS to publish their 'Quality Accounts' from April 2010 – just as they publish financial accounts. These will be reports to the public on the quality of services they provide in every service line – looking at safety, experience and outcomes. Easy-to-understand, comparative information will be available on the NHS Choices website at the same time. The Care Quality Commission will provide independent validation of provider and commissioner performance, using indicators of quality agreed nationally with DH, and publish an assessment of comparative performance.

18. The CQC will publish an annual report to Parliament on the provision of NHS care within England. Building on the strengths of the Healthcare Commission and the Commission for Social Care Inspection, the CQC will therefore provide assurance for the public that information about the quality of care is reliable.

91 The publication of surgical outcomes was recommended by the then Secretary of State for Health's Response to the Bristol Royal Infirmary Inquiry on 18 July 2001, who acknowledged that this would take time as such data needed to be "robust, rigorous and risk-adjusted."

4

19. I know that patients, staff and the public all want an NHS that is as good as any healthcare system in the world. Meeting this aspiration will require us to understand how we perform compared to other advanced healthcare systems. So we will work with other Organisation for Economic Cooperation & Development (OECD) countries and with the best academic institutions in the world and draw on our new national quality framework to agree some internationally comparable measures.

Recognising and rewarding quality improvement

20. The NHS should recognise and reward quality improvement. This means putting the right incentives in place to support high quality care.

21. We will ensure that from April 2009 the payment system for providers of NHS services is improved so that it better reflects clinical practice, recognises complexity of care – including the most specialised services – and supports innovation.[92] As outlined in *Chapter 3*, the Commissioning for Quality and Innovation Scheme (CQUIN) will also support local drives for improvement, concentrating on those aspects of quality that most need local attention.

22. We also want organisations that receive NHS funds to be able to plan for long-term improvements to patient care and ensure best value. For that reason, we will set out projections for tariff uplift and efficiency gains on a multi-year basis, aligning with future Spending Review periods and PCT allocations cycles.

23. Finally, to ensure we apply these principles as widely as possible, we will also extend payment and pricing systems to cover other services. For example, for mental health services, we will develop national currencies available for use from 2010/11. This will allow the comparison and benchmarking of mental health services, supporting good commissioning.

Raising standards

24. The locally owned nature of this Review has reinforced my belief that change is most effective not only when it responds clearly to patient needs but also when it is driven by clinicians based on their expert knowledge of conditions and care pathways. Change has not always been managed this way in the NHS. We will therefore put a strong clinical voice at every level in the NHS and we will increase our overall capacity to act on standards and information that support quality improvement. Where we have empowered local clinicians, they have risen to the challenge and delivered real improvements for their patients.

25. We will support clinical teams and clinical directors to develop their practice through peer review, continuing professional development and professional

92 For more on the new version of Healthcare Resource Groups (HRG4), which will be used as part of the Payment by Results funding system, please see www.ic.nhs.uk

revalidation. In secondary care, pioneering accreditation schemes have been developed in psychiatric specialties and, with our support, in radiology. The Royal College of General Practitioners is developing an accreditation scheme for GP practices, which is now being piloted and if appropriate, will be adopted nationally by 2010.

26. Locally, primary care trusts, on behalf of the populations that they serve, should challenge providers to achieve high quality care. This will require stronger clinical engagement in commissioning. This must go beyond practice-based commissioning and professional executive committees to involve all clinician groups in strategic planning and service development to drive improvements in health outcomes.

27. This will be achieved through the World Class Commissioning programme, which will hold primary care trusts to account for the involvement of the full range of informed clinicians. The assurance system that has been developed will draw on evidence including a feedback survey from clinicians, the quarterly practice based commissioning survey, practice-based commissioning governance arrangements and the five year strategic plan. This will be supplemented by interviews between the PCT board and a panel of independent experts, one of whom will be a clinician.

28. Senior clinical leadership at a regional level is currently provided by a Regional Director of Public Health, and a Nurse Director in each strategic health authority. By April 2009, the senior clinical leadership within SHAs will be enhanced with the appointment of new, dedicated SHA Medical Directors. Each SHA will bring forward proposals for medical directors that take account of the individual circumstances of the SHA.

29. The SHA medical directors will be responsible for overseeing implementation of the local clinical visions and providing medical leadership to NHS organisations in their area. They will work alongside regional directors of public health and work closely with professional executive committee chairs. They will have professional accountability to the NHS Medical Director at the Department of Health.

30. The senior clinical leadership team within each SHA will be supported by a SHA Clinical Advisory Group, appointed through competition. Each SHA will make proposals on how best to implement these arrangements.

31. The new arrangements will help sustain and support the strong clinical voice exemplified through this Review.

32. We will also ask each SHA to establish a formal Quality Observatory, building on existing analytical arrangements, to enable local benchmarking, development of metrics and identification of opportunities to help frontline staff innovate and improve

4

the services they offer. I expect that each Quality Observatory will wish to make its information available through portals such as NHS Evidence, to be run by NICE, and the NHS Choices website.

33. The Department of Health will continue to have a role in ensuring that the NHS recognises and prepares for national clinical priorities. We will establish a National Quality Board to provide strategic oversight and leadership on quality. It will oversee the work to improve quality metrics, advise the Secretary of State on the priorities for clinical standards set by NICE, and make an annual report to the Secretary of State on the state of quality in England using the internationally agreed comparable measures. The first report will be published by June 2009. It should draw from output of reviews and reports published by the Care Quality Commission and its predecessor on healthcare, the Healthcare Commission.

34. To demonstrate that quality is the responsibility of clinicians and managers throughout the system, the Board will be chaired by the NHS Chief Executive. Membership will include representation from the various national statutory bodies that make up the national 'quality landscape' for health and social care – including professional and statutory bodies. The aim of the Board will be to bring together all those with an interest in improving quality, to align and agree the NHS quality goals, whilst respecting the independent status of participating organisations.

Safeguarding quality: the role of intelligent regulation

35. Action to underpin this drive for improved quality through tough regulation is already underway. The first step has been to enhance the role of independent regulation, building on the achievements of existing regulators. The new Care Quality Commission will have a stronger focus on compliance and more flexible enforcement powers. It will ensure compliance with registration requirements for safety and wider quality that all health and adult social care providers will be expected to meet in order to be permitted to deliver services. It will provide independent information and assurance that systems for safety and quality are in place and working well, and it will help providers identify areas in need of improvement.

36. We have recently consulted on proposals that the new Care Quality Commission in time should regulate safety and quality for all GP and dental practices.[93] This would mean that, for the first time, any organisation providing primary medical or dental care will be subject to a consistent set of quality standards. The approach must be light-touch, risk-based and proportionate. The CQC will work with patients and the public, the NHS and the professions to develop this approach in practice and to determine where best to deploy its regulatory focus. And in doing so, the CQC will want to take account of the contribution that emerging

93 Department of Health, The future regulation of health and adult social in England, 25 March 2008.

professionally led accreditation schemes can play, both in primary care and elsewhere in health and social care.

Staying ahead: a pioneering NHS

37. Clinical practice is constantly improving, offering new opportunities to improve the quality of care. This means that if quality is really at the heart of everything we do, accepting, embracing and leading change is an imperative, not an option. Innovation must be central to the NHS. We established the Health Innovation Council to champion innovation for the NHS and help us develop the innovation proposals in this report.

38. We will continue to transform health research in the NHS by implementing, consolidating and building on the Government's strategy, *Best Research for Best Health*, for the benefit of patients and the public. Our researchers have made a great contribution and will continue to do so. However, too often innovation has been defined narrowly, focusing solely on research, when in fact innovation is a broader concept, encompassing clinical practice and service design. Service innovation means people at the frontline finding better ways of caring for patients – improving outcomes, experiences and safety. In this country, we have a proud record of invention, but we lag behind in systematic uptake even of our own inventions.[94]

94 See Darzi, *Healthcare for London: A Framework for Action*, Case for Change reason six, 2007

39. We want best practice everywhere as the platform from which innovation can flourish. This means doing away with outdated practice. Clearer standards from an expanded NICE will support commissioners to secure the best care for patients by disinvesting from superseded treatments, so ensuring NHS resources are focused on the most clinically and cost effective approaches.

40. To support local efforts to address unexplained variation in quality and universalise best practice, we will start to pay prices that reflect the cost of best practice rather than average cost. This will be enabled through the Best Practice Tariffs programme, which we will introduce where the evidence of what is best practice is clear and compelling. We will start in 2010/11 with four high-volume areas where there is significant unexplained variation in practice: cataracts, fractured neck of femur, cholecystectomy, and stroke care. We will discuss this proposal with clinicians and give further information on these areas later this year so that providers can plan in advance of tariff changes. The Best Practice Tariffs programme will be rigorously evaluated, not least to ensure that it is working for all the partners involved in the delivery of care, and if successful, expanded in future years.

41. Innovation will be driven regionally by strategic health authorities who will have a new legal duty to promote innovation. We will support frontline

4

innovation through the creation of a substantial new regional innovation funds held by SHAs. The funds' purpose will be to identify, grow and diffuse innovation. They will be supported and advised nationally, drawing on expertise and experience from those with a track record in fund management to ensure good rates of return on our investment in the future. An independent expert panel will assess local applications and make awards. In addition, we will create new prizes for innovations that directly benefit patients and the public. They will help foster an enterprise and innovation culture within the NHS. The prizes will be designed to engage a wide range of NHS staff and an expert panel and will be focused on tackling some of the major health challenges, such as radical breakthroughs in the prevention and treatment of lifestyle diseases.

42. We want to foster a pioneering health service that makes best use of the talents of NHS staff, the higher education sector and industry. International evidence from continental Europe, North America and the Far East, has demonstrated that patients benefit by bringing together the talents of different sectors. Their skills are harnessed in developing pioneering treatments and service models for patients. We will enable the stronger partnerships that bring these benefits through creating a new opportunity – Health Innovation and Education Clusters.

43. Health Innovation and Education Clusters will bring together many partners, across primary, community and secondary care, universities and colleges, and industry. They will be collaborations that set shared strategic goals for the benefit of member organisations. Their members will run joint innovation programmes that reflect their local needs and distinctiveness. They will also promote learning and education between their members. Bringing NHS organisations and higher education institutions together will enable research findings to be applied more readily to improve patient care.

44. Over time, in keeping with their aspirations and abilities, it will be possible for these clusters to be commissioned to provide postgraduate education and training of all healthcare professionals. This will help ensure that trainees get the breadth, depth and quality of training and teaching to provide the high quality care to which the NHS aspires.

45. Recognising the diversity of expertise and interests, these clusters will not be defined or imposed nationally, but will be enabled to emerge locally. They will build upon and reinforce successful models of collaboration that are already found in the NHS. We will invite applications from December 2008 for assigned status and funding and will award matched funding to proposals that deliver clear benefits to patients, as judged by an expert peer review process.

46. We also intend to foster Academic Health Science Centres (AHSCs) to bring together a small number of health and academic partners to focus on world-class research, teaching and patient care. Their purpose is to take new discoveries and promote their application in the NHS and across the world. Centres such as these will be where breakthroughs are made and then passed directly on to patients on the ward. There is no pre-defined number, although we have heard interest expressed by five to 10 organisations already.

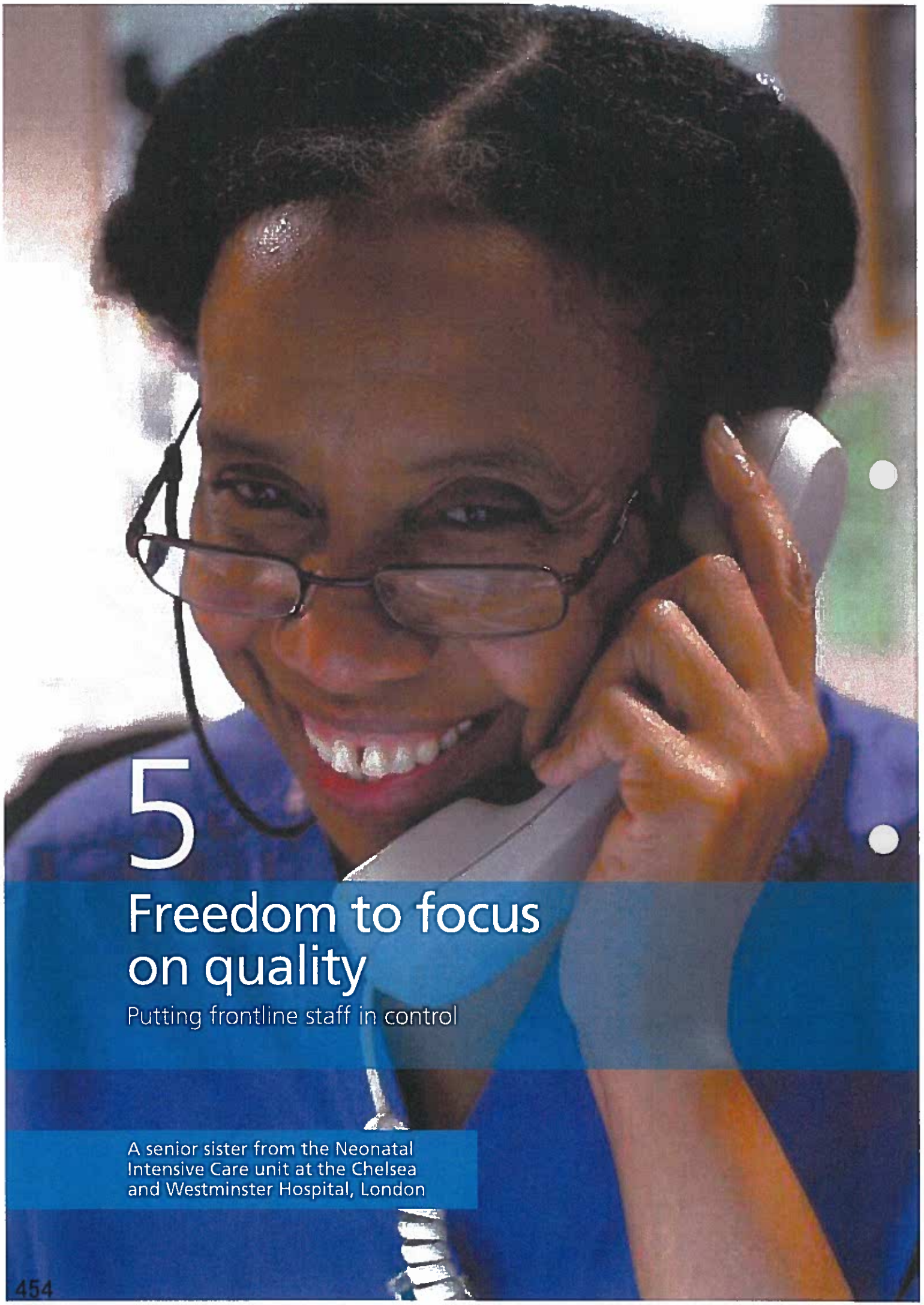
47. The best and most successful AHSCs will have the concentration of expertise and excellence that enables them to compete internationally. For these organisations, the peer set will not be simply this country or our European neighbours. They will compete globally with established centres such as those in the United States, Canada, Singapore, Sweden and the Netherlands.

48. We will define the criteria for becoming an Academic Health Science Centre (AHSC). In recognition of the global dimension, we will establish an international panel of experts to award this status. This will objectively determine whether organisations that aspire to this status have the appropriate concentration of expertise and excellence to be able to compete internationally. Those who have self-designated AHSC status will be subject to review by the international panel of experts.

49. The potential of AHSCs to deliver research excellence and improve patient care and professional education is tremendous. Clear governance arrangements with academe, which ensure this works for both patients and the NHS, will be very important. A number of governance models have already emerged to suit local circumstances; that is preferable to the imposition of a single model. Our approach will therefore be broadly permissive; we are open to proposals for different forms of governance on a case-by-case basis, including, potentially, changing legislation where this would help an AHSC to achieve the optimal governance model to support its success. We will work with interested organisations to develop these over the next year.

Conclusion

50. If everyone, from the hospital Chief Executive to the GP receptionist is primarily focussed on achieving high quality care for patients, we will have succeeded. Central initiatives, from fostering innovation to encouraging quality reporting can play their part. However, ultimately if high quality care is to become more than an ideal, we need to free the local NHS to concentrate on quality.



5 Freedom to focus on quality

Putting frontline staff in control

A senior sister from the Neonatal Intensive Care unit at the Chelsea and Westminster Hospital, London

5

Freedom to focus on quality

Putting frontline staff in control

Introduction

1. Our quality agenda can only succeed if the frontline NHS staff are given the freedom to use their talents. I, and my fellow clinicians, come to work to deliver health care. We try to improve our practice, but we need the freedom and opportunity to do so. When given that freedom through the process of this review, 2,000 clinicians, health and social care staff seized the opportunity to define the future of the NHS.

Unlocking talents

2. Healthcare is delivered by a team. The team includes clinicians,[95] managerial staff and those in supporting roles. All members of the team are valued. The sense of a shared endeavour – that all of us matter and stand together – was crucial in the inception of the NHS.

3. Every member of the team must be pulling in the same direction. Without the surgery receptionist, no patients would have appointments. Without the hospital porter, there would be no patient on the operating table. For patients, the team must go beyond individual organisations – they expect everyone in the NHS (and beyond into other public services such as social care, housing, education and employment) to work together, to give them the high quality, integrated care that they need and want.

4. In the past, the clinician's role within the team has often been confined to a practitioner, an expert in their clinical discipline. Yet frontline staff have the talent to look beyond their individual clinical practice and act as partners and leaders. In future, every clinician has the opportunity to be a:

   - *Practitioner*: Clinicians' first and primary duty will always be their clinical practice or service, delivering high quality care to patients based on patients' individual needs. This means working with patients, families and carers in delivering high quality, personal care, the most effective treatments and seeking to keep people healthy as well as treating them when they are sick. It is an agenda that reinforces the importance of professional judgement, creativity and innovation.

95 Clinicians include those staff who provide clinical care to patients and the public, including doctors, dentists, nurses, midwives, healthcare scientists, pharmacists, allied health professionals, clinical support workers and paramedics.

5

- *Partner*: Clinicians must be partners in care delivery with individual and collective accountability for the performance of the health service and for the appropriate use of resources in the delivery of care. Partnership requires clinicians to take responsibility for the appropriate stewardship and management of finite healthcare resources. Partners will be expected to work closely with others in the health service and beyond, such as social care colleagues, children's centres and schools, to manage the balancing of individual and collective needs, integrating care around patients.

- *Leader*: Clinicians are expected to offer leadership and, where they have appropriate skills, take senior leadership and management posts in research, education and service delivery. Formal leadership positions will be at a variety of levels from the clinical team, to service lines, to departments, to organisations and ultimately the whole NHS. It requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients.

5. These three ways in which clinicians can use their talents are already in evidence in parts of the NHS and internationally.[96] The best work on professionalism is also acknowledging clinicians' wider roles in the NHS.[97]

6. The exact balance between practitioner, partner and leader will be different, depending on the professional role undertaken. For those in formal leadership roles, such as clinical directors, a majority of their time is spent as leaders. For many, clinical practice will continue to dominate – though they will still need to work with others as partners and show the necessary leadership to keep practice up-to-date and deliver the best possible care for their patients.

7. What is clear is that this new professionalism, acknowledging clinicians' roles as partners and leaders, gives them the opportunity to focus on improving not just the quality of care they provide as individuals but within their organisation and the whole NHS. We enable clinicians to be partners and leaders alongside manager colleagues through the following principles:

   - **Giving greater freedom to the frontline**. We will continue the journey of setting frontline staff, both providers and commissioners, free to use their expertise, creativity and skill to find innovative ways to improve quality of care for patients.

96 The formulation "practitioner, partner, leader" builds upon international experience best exemplified by Kaiser Permanente's approach to clinical leadership in the United States.

97 For examples of where this is already taking place, see Doctors in Society (Royal College of Physicians 2005) and *Understanding Doctors. Harnessing Professionalism* (King's Fund and Royal College of Physicians 2008).

- **Creating a new accountability**. Setting NHS staff free from central control requires a new, stronger accountability that is rooted in the people that the NHS is there to serve. It means the service should look out to patients and the communities they serve not up the line.

- **Empowering staff**. Professionals need to be empowered to make the daily decisions that improve quality of care and we will enable this to happen.

- **Fostering leadership for quality**. All these steps together create the right environment for high quality care to happen, but we need to further develop clinical and managerial leadership.

Giving greater freedom to the frontline

Acute, mental health, and ambulance trusts

8. The journey of setting NHS organisations free from central direction began with the creation of NHS trusts and, subsequently, NHS foundation trusts. It continues. Our commitment to making acute, mental health and ambulance trusts into NHS foundation trusts remains strong. It is our clear ambition that in future hospital care will be provided by NHS foundation trusts. In order to achieve this, we will aim to accelerate the rate at which existing NHS trusts achieve NHS foundation trust status.

9. We will extend these freedoms to community providers, exploring a range of options including social enterprises and community foundation trusts. However, there are some providers, for example high secure units, where NHS foundation trust status is not appropriate. Here we will aim to give similar freedoms to organisations, which achieve and maintain similar levels of good governance and financial stability to those required of NHS foundation trusts.

10. It is important that provider organisations enjoy these new and existing freedoms in the context of the national framework. We will therefore continue to ensure that FTs and other providers meet agreed standards for quality of care and choice, and take account of the new NHS Constitution.

11. The freedom of NHS foundation trusts to innovate and invest in improved care for patients is valuable and essential. We welcome recent initiatives that have seen some NHS foundation trusts share the proceeds of their success with all of their staff, from the porter to the senior clinician, and encourage more to do likewise.[98] These autonomous organisations are ideally placed to respond to patient expectations of high quality care.

98 Gloucestershire Hospitals NHS foundation trust announced that all staff would benefit from a £100 bonus, BBC Online, 14 December 2007.

5

Community services

12. We now need to give greater freedom to those working in community services. So far, they have not had the same opportunities for more autonomy. Over a quarter of a million nurses, midwives, health visitors, allied health professionals, pharmacists and others work in community health services. They have a crucial role to play in providing some of the most personalised care, particularly for children and families, for older people and those with complex care needs, and in promoting health and reducing health inequalities.

13. We believe that staff working in community services deserve the same deal as those working in any other part of the NHS. They speak with passion about the potential for using their professional skills to transform services, but are frustrated at the historic lack of NHS focus on how to free up these talents. We will support the development of vibrant, successful provider services that systematically review quality and productivity, including new ways of working in partnership with others, to free up more time for patient care and to improve health outcomes.

14. We will support the NHS in making local decisions on the best governance and organisational models to support the development of flexible, responsive community services. Some primary care trusts have already done this by developing arm's-length provider organisations that remain accountable to the Board. In other areas, the NHS is exploring new approaches such as community NHS foundation trusts or social enterprises.

15. We recognise concerns about staff pension rights when new organisational arrangements are being introduced. Where PCTs and staff choose to set up social enterprise organisations, transferred staff can continue to benefit from the NHS Pension Scheme, while they work wholly on NHS funded work. We will support local decision-making by drawing together and publishing advice on this range of organisational options and their implications for issues such as governance, patient choice, competition and employment.

16. We will also encourage and enable staff to set up social enterprises by introducing a staff 'right to request' to set up social enterprises to deliver services. PCTs will be obliged to consider such requests, and if the PCT board approves the business case, support the development of the social enterprise and award it a contract to provide services for an initial period of up to three years.

NHS commissioners

17. NHS commissioners, working with their local authority partners through mechanisms such as joint strategic needs assessments, exist to champion the interests of patients, families and the communities in which they live to get the right care, in the right place,

at the right time. They manage the local health system on behalf of patients, the public and staff. The work that Sir Ian Carruthers OBE has led during this Review has shown how commissioners can exercise their responsibility to secure high quality sustainable care for their populations including in rural areas through a range of innovative delivery models. The World Class Commissioning programme is designed to raise ambitions for a new form of commissioning that deliver better health and well-being for the population, improving health outcomes and reducing health inequalities – adding life to years and years to life.[99]

18. This programme has tremendous potential and needs to be challenging about the capability of many of our commissioners and how far we have got with practice-based commissioning. It must provide strong support and encouragement to PCTs to develop quickly. As part of this programme, where primary care trusts have demonstrated that they are improving health outcomes, they will be given greater freedom over the priorities they set and the methods, people and approaches they employ. We will set out these freedoms in the autumn.

19. PCTs are the leaders of the local NHS, and should be seen this way. All PCTs will be free to take the name of their locality, so that instead of being 'somewhere PCT', they are 'NHS somewhere', e.g. NHS Blackpool. This properly reflects that they are the NHS organisation responsible and accountable for the health of the population of that area.

20. We will support primary care trusts as they become World Class Commissioners, with both local and national development resources. As part of this, the Department of Health, on behalf of the strategic health authorities, will establish a list of independent sector organisations that can help primary care trusts to develop the capabilities of their management boards.

Creating a new accountability

21. With greater freedom must come a new and enhanced accountability. As the NHS achieves once aspirational targets such as 18 weeks from referral to treatment, halved infections rates, and a maximum wait of four hours in accident and emergency, so these ambitions become established as minimum standards. In future, new and essential national challenges will be met through robust minimum standards and by ensuring that national priorities are reflected in local commissioning. There will be no additional top-down targets beyond the minimum standards.

22. Our new approach to accountability will be through openness on the quality of outcomes achieved for

99 For more on world class commissioning see Department of Health, *World Class Commissioning: Competencies and Vision*, December 2007

5

patients. Professional regulation has ensured that practitioners are accountable to their individual patients during their episode of care. By focusing on the overall outcome, it means that the new accountability is for the whole patient pathway – so clinicians must be partners as well as practitioners. All the different parts of the system – different organisations and professional groups – must stack up behind one another to achieve the best outcome for patients.

23. There will be no national targets set for quality performance, but, as explained in Chapter 4, the outcomes achieved by every NHS organisation will be openly available. In this way, clinicians, and the organisations they work in, will be held to account by their patients, their peers and the public. Measuring and valuing what matters most to patients, the public and staff is the way in which we will enable the NHS to make progress towards high quality care. We believe this transparency will facilitate meaningful conversations between teams and members of teams about how they can continuously improve the quality of care they deliver.

24. This transparency must not be limited to acute health services. Therefore, from next year, we will develop and pilot a quality framework for community services. Later this year, we will complete work on a standard, but flexible, contract to enable commissioners to hold community health services to account for quality and health improvement. We will also increase transparency by moving away from 'block contract' funding.

25. NHS commissioners will be held to account for the quality of health outcomes that they achieve for the populations they serve, including the most vulnerable or excluded people with complex care needs. We have developed a new assurance system that combines local flexibility with strengthened accountability.[100] It is one nationally consistent approach, managed locally by strategic health authorities, and includes an annual assessment of health outcomes, competences and governance as well as providing a commentary on their potential for improvement. All primary care trusts will have implemented the assurance system by March 2009, and the first results will be formally published in March 2010.

Empowering staff

26. If clinicians are to be held to account for the quality outcomes of the care that they deliver, then they can reasonably expect that they will have the powers to affect those outcomes. This means they must be empowered to set the direction for the services they deliver, to make decisions on resources, and to make decisions on people.

27. In acute care, giving nurse managers authority and control over resources will lead to better, safer, cleaner wards and a higher quality patient experience. Giving clinical directors the power to make decisions on the services they offer, the appraisal and management of their staff and the

100 Department of Health, *World Class Commissioning Assurance System*, June 2008.

way in which they spend their budgets will lead to better quality outcomes for patients.[101] Through our new approach to 'leadership for quality' we will support clinicians as they take on these roles.

28. The purpose of practice-based commissioning is to empower family doctors and community clinicians to assemble high quality care around the needs of patients. It should put clinical engagement at the heart of the commissioning process. We have heard the message, however, that it has not lived up to this aspiration. That is why we will work with the NHS and with the professions to redefine and reinvigorate it.

29. We will give stronger support to practice-based commissioning. This means we will provide incentives for a broader range of clinicians to get involved, so that it brings family doctors together with other community clinicians and with specialists working in hospitals to develop more integrated care for patients. We will distinguish more clearly between the collaborative, multi-professional work involved in commissioning better care for GP practice populations and the role of GP practices in providing an enhanced range of services for their patients. And we will ensure that primary care trusts are held fully to account for the quality of their support for practice based commissioning, including the management support given to PBC groups and the quality and timeliness of data (e.g. on budgets, referrals and hospital activity).

30. We will empower clinicians further to provide more integrated services for patients by piloting new integrated care organisations (ICOs) bringing together health and social care professionals from a range of organisations – community services, hospitals, local authorities and others, depending on local needs. The aim of these ICOs will be to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices). We will invite proposals shortly.

Fostering leadership for quality

31. Greater freedom, enhanced accountability and empowering staff are necessary but not sufficient in the pursuit of high quality care. Making change actually happen takes leadership. It is central to our expectations of the healthcare professionals of tomorrow. There are many routes to excellent leadership and we do not claim to have all the answers. But we do want people to be able to have meaningful conversations that transcend organisational boundaries. That is why we have identified the core elements of any approach to leadership, which we expect all those leading change in the NHS to be clear about:

101 Evidence from the US shows that hospitals with a higher proportion of clinically trained managers are better managed (Source: McKinsey analysis).

5

- **Vision**. What quality improvements they are trying to achieve and how it will benefit patients and local communities.
- **Method**. How they will make change happen – the management method they will use for implementation, continuous improvement and measuring success.
- **Expectations**. What the difference will mean for people, the behavioural change that will be necessary and the values that underpin it.

32. As explained in the publication *Leading Local Change*,[102] change in the NHS should always be of benefit to individual patients and the population as a whole, should be clinically driven and locally led, with patients, the public and staff involved. In the NHS constitution, we pledge to staff that they will be engaged in the decisions that affect them. Leadership has been the neglected element of the reforms of recent years. That must now change.

33. It is unrealistic to expect NHS staff to take on leadership without action to make it integral to training and development. So we will explore ways to ensure that the undergraduate curricula for all medical and nursing students reflect the skills and demands of leadership and working in the NHS. We will also ensure that leadership development is an integral part of modernising careers programmes for other healthcare professions.

34. For those at a postgraduate or equivalent stage in their careers, we will explore ways to ensure that both the curricula and appraisal processes reflect the importance of learning leadership skills. For those with a particular interest in leadership, we will support strategic health authorities and health innovation & education clusters to establish Clinical Leadership Fellowships so that they have dedicated time to spend on enhancing their leadership skills.

35. The local NHS already makes considerable investments in leadership development programmes, for clinicians and managers alike. We have heard that these can be variable in their scope and standard. That is why we will introduce a new standard in healthcare leadership, the Leadership for Quality Certificate. It will operate at three levels. Level 1 will be for members of clinical and non-clinical teams with an interest in becoming future leaders. Level 2 will be for leaders of team and service lines, and Level 3 will be for senior directors (e.g. medical, nursing, operations).

36. At the most senior levels, we will identify and support the top 250 leaders in the NHS. This group will include both clinical and non-clinical leaders. They will get close support in their personal development, mentoring, and active career management.

102 Darzi A., *NHS Next Stage Review: Leading Local Change* (2008).

37. We will establish an NHS Leadership Council which will be a system-wide body chaired by the NHS Chief Executive, responsible for overseeing all matters of leadership across healthcare, including the 250 leaders. It will have a particular focus on standards (including overseeing the new certification, the development of the right curricula, and assurance) and with a dedicated budget, will be able to commission development programmes.

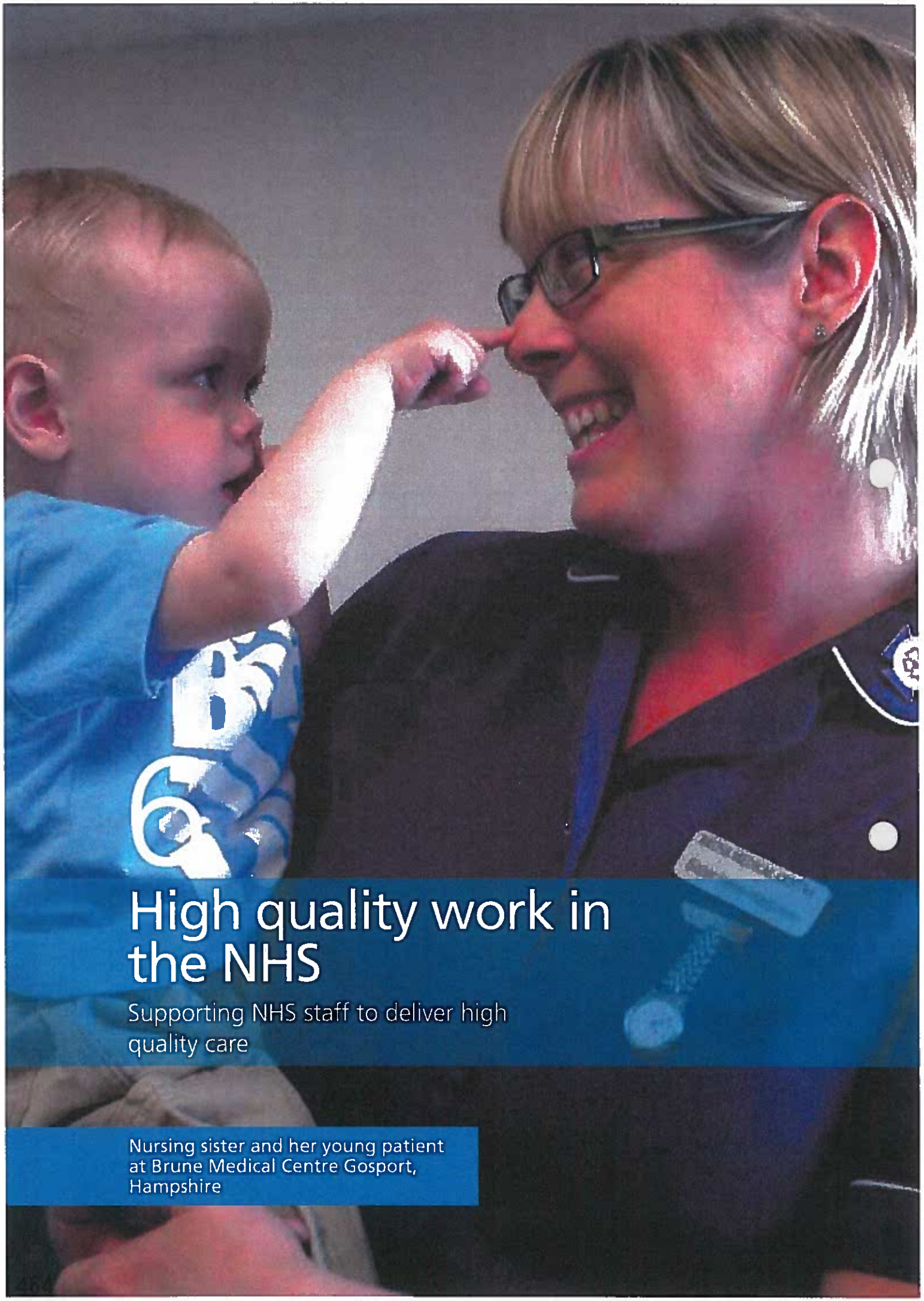
38. The NHS Medical Director and National Clinical Directors will also work with senior clinicians to ensure that clinical leadership becomes a stronger force within the NHS. Compared to healthcare organisations in the US, such as Kaiser Permanente, the NHS has very few clinicians in formal leadership roles. For senior doctors, the operation of the current Clinical Excellence Awards Scheme will be strengthened – to reinforce proposals in this chapter to drive quality improvement. New awards, and the renewal of existing awards, will become more conditional on clinical activity and quality indicators; and the Scheme will encourage and support clinical leadership. The scheme will also become more transparent, with applications being publicly available. The profession will be involved in developing and introducing these amendments. In making national awards, the independent Advisory Committee on Clinical Excellence Awards (ACCEA) will have regard to advice from the National Quality Board and the NHS Leadership Council.

39. Finally, leadership is not just about individuals, but teams. Successful organisations are led by successful Boards. We will immediately commission a new development programme for trust boards through the NHS Chief Executive and the new NHS Leadership Council. In addition, we will encourage the development of Masters-level programmes which are relevant to the health sector by providing matched funding to SHA-commissioned programmes.

Conclusion

40. NHS staff make the difference for patients and communities. It is through unlocking talent that we will achieve high quality care across the board. Many of the features described in this chapter already exist in the best of the NHS, but not systematically so.

41. We seek to change that not by central control, but by freeing NHS staff and organisations to make the right decisions. Therefore, we will extend and improve existing reforms such as NHS foundation trusts and practice based commissioning. Through these changes, healthcare professionals will be not just practitioners, but partners and leaders.



High quality work in the NHS

Supporting NHS staff to deliver high quality care

Nursing sister and her young patient at Brune Medical Centre Gosport, Hampshire

6

High quality work in the NHS

Supporting NHS staff to deliver high quality care

1. To encourage staff who commission and provide NHS services to take up new opportunities and freedom, we must ensure they can benefit from supportive working environments. High quality work means well-designed, worthwhile jobs, support for learning and development, in high quality workplaces, with NHS staff being respected for the caring and compassionate nature of the services they provide.

2. There has been significant change over the past decade. Pay and conditions have been made fairer. This was an almost silent revolution in making sure that the NHS recognises and rewards the talents of all its staff. Significant workforce contracts were changed, in partnership with the professions. There was an unprecedented investment in education and training that saw the largest expansion in the numbers of doctors, nurses, and other clinicians for a generation.

3. The service is no longer a single national employer – staff involved in NHS services are employed by their respective organisations, and the first steps to improving the quality of work must always be taken locally. Nevertheless, there are two issues that we face nationally and require national solutions:

   - **High quality workplaces**. We will be clear about what we expect of one another, what staff can expect of NHS employers, and take practical steps to improve the quality of workplaces.

   - **High quality education and training**. Working in partnership with professional representatives, we have developed proposals to improve the system of workforce planning, commissioning and the provision of education and training. The key features are described here, with the technical details in a separate document *NHS Next Stage Review: A High Quality Workforce* published alongside this report. Education and training also extends to ensuring that NHS managers have the skills they require.

High quality workplaces

4. I know from experience that working in the NHS can sometimes be frustrating, and I have heard that message over the course of the Review. The great strength of the NHS is that we are all part of the same system. This should mean that we are all able to work effectively together for the benefit of patients. Too often, however, when NHS work cuts across organisations the needs

6

of patients are not put first. There is a tendency to put the perceived interest of the organisations first, and to shirk responsibility for patients. There also remains an infuriating 'not invented here' resistance to adopting new ways of working that can improve patient care.

5. That is why we need to be clear about what it is that we stand for and what we expect of one another. NHS-wide values transcend individual organisations. They are a great strength but we do not often talk explicitly about them. Over the past year, we have carried out extensive work to identify and understand the values of patients, the public and NHS staff. These values are what patients, staff and the public tell us they stand for. They are included in the draft NHS Constitution.

   The NHS values have been derived from extensive discussions with staff, patients and the public. They are:

   - **Respect and dignity**. We value each person as an individual, respect their aspirations and commitments in life, and seek to understand their priorities, needs, abilities and limits. We take what others have to say seriously. We are honest about our point of view and what we can and cannot do.

   - **Commitment to quality of care**. We earn the trust placed in us by insisting on quality and striving to get the basics right every time: safety, confidentiality, professional and managerial integrity, accountability, dependable service and good communication. We welcome feedback, learn from our mistakes and build on our successes.

   - **Compassion**. We find the time to listen and talk when it is needed, make the effort to understand, and get on and do the small things that mean so much – not because we are asked to but because we care.

   - **Improving lives**. We strive to improve health and wellbeing and people's experiences of the NHS. We value excellence and professionalism wherever we find it – in the everyday things that make people's lives better as much as in clinical practice, service improvements and innovation.

   - **Working together for patients**. We put patients first in everything we do, by reaching out to staff, patients, carers, families, communities, and professionals outside the NHS. We put the needs of patients and communities before organisational boundaries.

   - **Everyone counts**. We use our resources for the benefit of the whole community, and make sure nobody is excluded or left behind. We accept that some people need more help, that difficult decisions have to be taken – and that when we waste resources we waste others' opportunities. We recognise that we all have a part to play in making ourselves and our communities healthier.

6. These values are the best of the NHS and should inform and shape all that we do. The NHS-wide values are not exclusive – they can and should sit side-by-side with the particular values in any individual organisation, supporting and reinforcing one another. But they should guide our behaviour when working *across* organisations in the system. Living up to their letter and spirit should lead to higher quality workplaces and better services for those who use the NHS.

7. We believe that being clear about our values should help ensure high quality work. But staff are rightly keen to know the practical differences we will make too. In the NHS Constitution we will therefore make four pledges to all NHS staff, from the porter to the community nurse, the medical director to the chief executive. The NHS will strive to:

   - Provide all staff with well-designed, rewarding jobs that make a difference to patients, their families and carers, and communities.
   - Provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed.
   - Provide support and opportunities for staff to keep themselves healthy and safe.
   - Actively engage all staff in decisions that affect them and the services they provide, individually and through representatives. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

8. Just as the quality of care needs to be measured and published, the same approach should apply to the quality of work. That is why we have agreed with the Healthcare Commission that staff satisfaction will be an indicator in the annual evaluation of NHS trusts and NHS foundation trusts.

9. We will empower staff to hold their employers to account for the investment they make in learning and development. We will require every organisation that receives central funding for education and training to adopt the Government Skills Pledge,[103] to nominate a member of the board to be responsible, and to publish its annual expenditure on continuing professional development so that present and future employees can make choices that are more informed.

10. We will support staff with easier access to the tools they need to do their jobs. We will establish mystaffspace as a convenient, one-stop portal for all staff. Through it they will be able to access the new NHS Evidence knowledge portal and get information on what high quality care looks like and how to deliver it, tailored to their own professional expertise and interests. They will also be able to access information on

103 http://inourhands.lsc.gov.uk/employersSkillsPledge.html

6

performance against the NHS quality framework, their own personal staff records, their credentials, and a log of their learning and development. NHS Mail will be there too. Mystaffspace will give all NHS professionals better access to the information they need to deliver excellent patient care.

High quality education and training

11. High quality care for patients is an aspiration that is only possible with high quality education and training for all staff involved in NHS services. They provide care in a changing healthcare environment. New roles are emerging. New technology is changing the way they work. Patients and the public, quite rightly, have increasing expectations of personalised care. Workforce planning, education and training needs to change to enable staff to respond more effectively and flexibly to this dynamic environment.

12. The focus needs to be on the roles, education and training and careers paths that will enable the NHS to deliver their visions for quality care. We have worked in partnership with all the professions and the service and many others to identify the changes that are needed to map out a bright future. The issues highlighted here are addressed comprehensively in the *NHS Next Stage Review: A High Quality Workforce* published today alongside this report.

Clearer roles

13. For all health professions, we are working in partnership with their professional bodies, employers and other stakeholders to define the unique role and contribution of each of them and how their roles are changing across the pathways of care. From this starting point, and with excellent quality of care as our primary, unifying goal, we will work together to define the skills and expertise they require, and ensure that these are underpinned by appropriate educational standards and programmes.

14. We will demonstrate how these roles link with one another by establishing explicit career pathways, which make career progression clearer, easier and more flexible. We will also introduce modularised, accredited training packages and strengthen educational governance to ensure that all clinical staff have the opportunity to develop their skills throughout their careers for the benefit of patients, employers and their own career progression.

15. We will also continue our work to modernise clinical careers so that jobs and career opportunities continuously improve.

16. Foundation periods of preceptorship for nurses at the start of their careers help them begin the journey from novice to expert. There will be a threefold increase in investment in nurse and midwife preceptorships. These offer protected time for newly qualified nurses and midwives to learn from their more senior colleagues during their first year.

A locally led approach

17. Our approach to reforming workforce planning and education mirrors that for the provision of high quality care – a belief that quality is best achieved by devolving decision making to the frontline in an environment of transparency and clear accountabilities and where the role of education commissioner and education provider are clearly separated. We will ensure that the workforce is able to meet the needs of patients by developing workforce elements of service plans, using the eight pathways of care of the Review as the basis for identifying what patients need, now and in the future.

18. The new system will require leadership and management of workforce planning and education commissioning throughout the NHS. This approach requires a stronger and more constructive partnership with all professions. That is why we are establishing new professional advisory bodies to enable the professions to contribute to strategic workforce development at all levels. They will bring a single coherent professional voice to advise on how best to achieve our vision of the high quality education and training that underpins high quality care for patients.

19. We will establish an independent advisory non-departmental public body, Medical Education England (MEE), by the end of this year, to advise the Department of Health on the education and training of doctors, dentists, pharmacists and healthcare scientists which needs to be planned nationally. MEE nationally will be supported by similar advisory bodies in every NHS region. Together, they will provide scrutiny and advice on workforce plans and education commissioning strategies to ensure that the NHS has the right quantity and quality of doctors, dentists, pharmacists and healthcare scientists for the future. We will work with the other professions to decide what other national advisory boards are required, recognising the contribution of the diversity of professional roles within multi-disciplinary team to deliver effective evidence-based care.

20. The national and local professional advisory bodies and the wider healthcare system will be supported by a Centre of Excellence, which, from April 2009, will provide objective long-term horizon scanning, capability and capacity development for workforce planning functions, and the development of technical planning assumptions. It will also enable capacity and capability to make the system work.

Fair and transparent funding

21. We are reforming the funding of education and training to make it fairer, more transparent and ensure that it is used for the purpose for which it is intended. It is for those reasons that we will replace the current historical funding arrangements for the Medical

6

Professional Education and Training (MPET) budget with a tariff based system where the funding follows the trainee. These arrangements will reward quality, promote transparency and protect investment in education and training. With clarity about the resources dedicated to education and training, education commissioners will be empowered to hold providers of that education and training to account, also taking into account the 'voice' and choices of trainees.

22. Nationally, we will seek to extend apprenticeship opportunities in the service – recognising that healthcare support staff – clinical and non-clinical – are the backbone of the service. We will therefore double our investment in apprenticeships over the next four years, and continue to work with trade unions and Skills for Health to identify the appropriate use of apprenticeships within each clinical career framework, and in non-clinical roles.

23. 60 per cent of staff who will deliver NHS services in 10 years time are already working in healthcare. We need to make sure that they are able to keep their skills and knowledge up to date so that they can provide services that meet the changing needs of both patients and local communities. Continuing professional development (CPD) is rightly the responsibility of individual employers. Some do this well, but this is not always the case[104]. We therefore intend to strengthen the arrangements to ensure staff have consistent and equitable opportunities to update and develop their skills.

24. These and other changes set out in *NHS Next Stage Review: A High Quality Workforce* will ensure that we have a system for workforce planning, education and training that will be sustainable for the long term. Staff will have clearer career frameworks and be able to make informed careers choices. Employers will have a stronger voice in workforce planning and education commissioning and provision and a more flexible workforce. Patients will receive high quality care delivered by highly trained staff and planned around their needs. The public will receive better value for money from national education resources.

Support for managers

25. NHS management includes both those who have clinical backgrounds and those who do not. Regardless of whether they have a clinical or non-clinical background, managers and frontline clinicians must forge a strong partnership, sharing successes or setbacks. In all cases, managers must be involved in the core business of clinical practice, helping, supporting and challenging clinicians to deliver the best possible care for

104 Although standard, consistent information on training is very difficult to obtain due to the variety of approaches organisations take in budgeting for training.

patients. This means ensuring that systems work effectively, whether they be patient flows, community disease management, theatre operations or commissioning services.

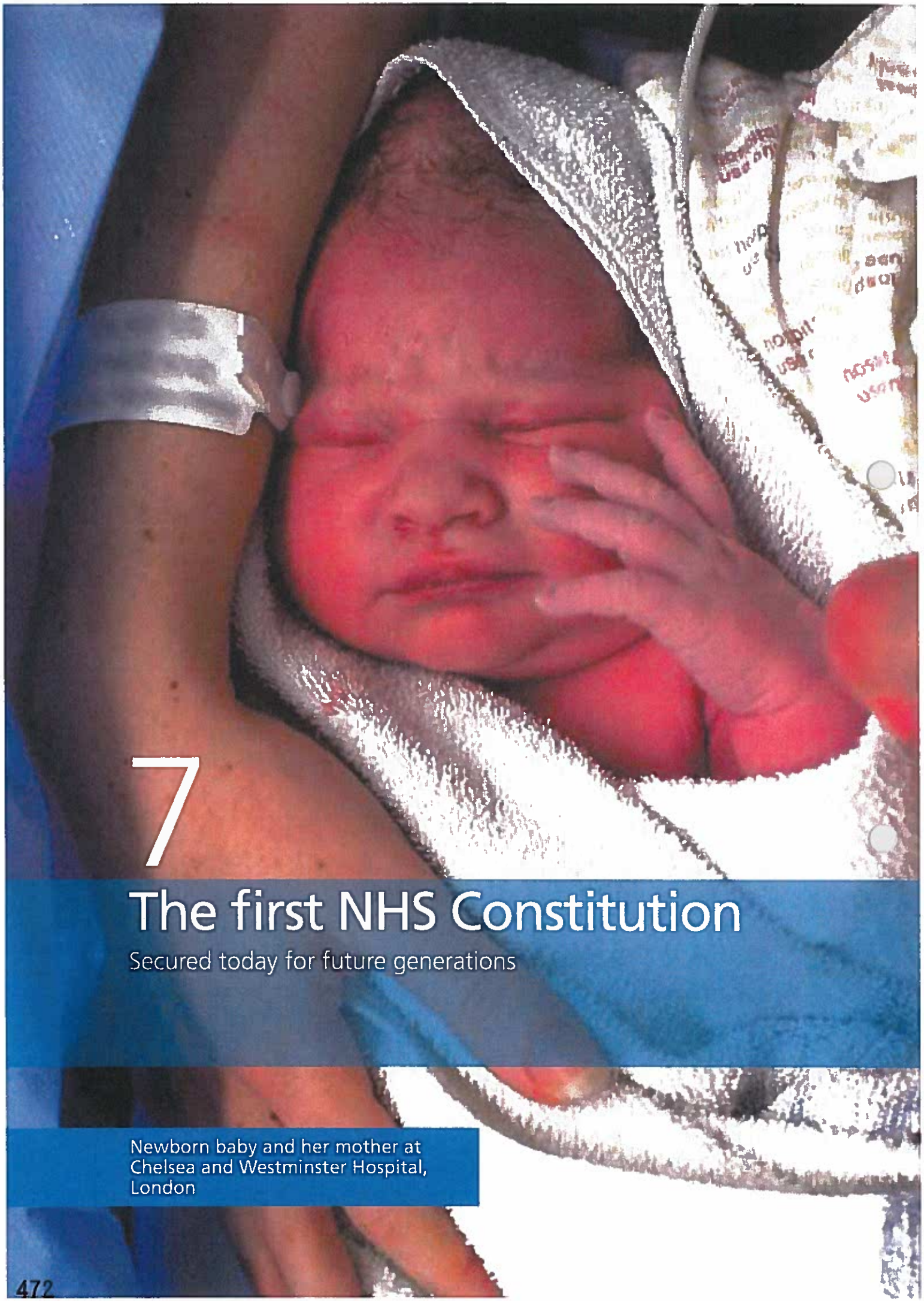
26. Support already exists to help managers develop these skills. Indeed, the existing programmes for management development are often applauded. These include the award-winning Management Trainee Scheme (MTS) for graduates, the Gateway scheme for individuals from sectors other than health, and the Breaking Through scheme that supports black and minority ethnic people that wish to pursue careers in NHS management. Although the MTS welcomes applications from qualified clinicians who wish to become full-time managers, at present there is no dedicated scheme for clinicians wishing to develop their management and leadership skills.

27. Therefore, we will establish a new programme to equip and support clinicians in leadership and management roles. It will be called the 'Clinical Management for Quality' programme. It will be dedicated to those clinicians leading clinical services lines, with a particular focus on clinical directors and leaders in primary care who are running practice-based commissioning or integrated care organisations.

28. As responsibility is devolved to the local NHS, there will be greater scrutiny of managers. Whilst the overwhelming majority of NHS managers meet high professional standards every day, a very small number of senior leaders sometimes demonstrate performance or conduct that lets down their staff, their organisations and the patients that they serve. We do not believe a full-blown system of statutory professional regulation – akin to a General Medical Council – would be proportionate at this time, but the Department will work with the profession, the NHS and other stakeholders to ensure that there are fair and effective arrangements to prevent poorly performing leaders from moving on to other NHS organisations inappropriately. While an enhanced Code of Conduct for managers will underpin this, we will consider whether more effective recruitment procedures or a more formal system of assuring suitability for future employment would provide more effective and proportionate safeguards.

29. Conclusion

30. Just as patients deserve high quality care, so NHS staff deserve high quality work. If frontline staff are going to focus on improving the quality of care provided by the NHS, they need the right working environments and the right training and education.



7

The first NHS Constitution

Secured today for future generations

Newborn baby and her mother at Chelsea and Westminster Hospital, London

7

The first NHS Constitution

Secured today for future generations

1. The NHS belongs to the people. It is there to improve our health, supporting us to keep mentally and physically well, to get better when we are ill and, when we cannot fully recover, to stay as well as we can. It works at the limits of science – bringing the highest levels of human knowledge and skill to save lives and improve health. It touches our lives at times of basic human need, when care and compassion are what matter most.

2. To provide high quality care for all, the NHS must continue to change. But the fundamental purpose, principles and values of the NHS can and must remain constant. Setting this out clearly, along with the rights and responsibilities of patients, the public and staff, will give us all greater confidence to meet the challenges of the future on the basis of a shared understanding and common purpose.

3. That is why in my interim report I committed to exploring the merits of introducing a Constitution for the NHS. As a result of the work of this Review, I am now convinced that there is a strong case for introducing the first NHS Constitution.

The case for a constitution

4. An NHS Constitution will:

- **Secure the NHS for the future.** The Constitution will set out clearly the enduring principles and values of the NHS, and the rights and responsibilities for patients, public and staff.

- **Empower all patients and the public.** Patients already have considerable legal rights in relation to the NHS, but these are scattered across different legal instruments and policies. Some are obscure; many people are not aware of all of their existing rights. The Constitution will empower all patients by summarising all existing rights in one place.

- **Empower and value staff.** NHS services are provided by over 1.3 million staff. Those staff are our most important resource. For the NHS Constitution to be an enduring settlement, it needs to reflect what we are offering to staff: our commitment to provide all staff with high quality jobs along with the training and support they need.

7

- **Create a shared purpose, values and principles**. As the NHS evolves, a wider range of providers, including those from the third and independent sectors are offering NHS-commissioned services. Patients expect that wherever they receive their NHS-funded treatment, the same values and principles should apply. All organisations are part of an integrated system for the benefit of patients. That is why we will set out the purpose, principles and values for the NHS in the Constitution. We propose that all organisations providing NHS services are obliged by law to take account of the Constitution in their decisions and actions.

- **Strengthen accountability through national standards for patients and local freedoms to deliver**. The NHS is held to account nationally through Parliament, even though services are delivered locally. The Constitution is an opportunity to clarify and strengthen both national and local accountability. In discussions with patients, public and staff, we have received a clear message that they are committed to the NHS as a national system, paid for out of general taxation; from which they can expect certain standards of care and access. The draft NHS Constitution therefore makes clear what people can expect from the NHS no matter where they live.

How the Constitution was developed

5. The NHS Constitution that we are publishing in draft today has been developed in partnership with patients, public, staff and a number of experts.

6. During this extensive programme of development, engagement and research we heard that:[105]

   - To qualify as a Constitution, the document needed to be short and enduring
   - The Constitution should be flexible and not hold the NHS back in terms of its ambitions for improving the quality of care
   - For the Constitution to be meaningful it must have bite, with means for enforcement and redress, not just warm words or aspirations
   - There was no appetite for a 'lawyers' charter', and concern that we should avoid fuelling litigation

Our first NHS Constitution

7. The draft NHS Constitution now sets out in one place the purpose, principles and values of the NHS, and the rights and responsibilities of patients, the public and NHS staff.

105 This included a literature review conducted by the London School of Hygiene and Tropical Medicine looking at international experience; Elizabeth Clery, *Trends in Attitudes to Health Care 1983 to 2005 Report based on results from the British Social attitudes Survey*; a series of discussion events with patients, the public and staff; and meetings with leading experts.

8. It reaffirms the commitment to a service which is for everyone, based on clinical need and not an individual's ability to pay.

9. As well as collecting together important rights for both patients and staff, it sets out a number of pledges which reflect where the NHS should go further than the legal minimum. Each right or pledge is backed up by an explanation, in the accompanying *Handbook to the NHS Constitution*, on how they will be enforced and where to seek redress.

10. We intend to legislate, as soon as Parliamentary time allows, to require:

    - All NHS bodies and private and third sector providers providing NHS services to take account of the Constitution in their decisions and actions

    - Government to renew the NHS Constitution every 10 years, with the involvement of the patients who use it, the public who fund it and the staff who work in it

11. The *Handbook to the NHS Constitution* will be refreshed at least every three years. As well as setting out the legal basis for all of the rights, it sets out how the performance management and regulatory regime of the NHS will ensure that the pledges in the Constitution are delivered.

Accountability in the NHS

12. The NHS remains a national health service, funded through national taxation. It is right, therefore, that it should be the Government that sets the framework for the NHS and is held accountable in Parliament for the way that it operates. There must be a continuous thread of accountability through the system to the Government of the day; and it is for that reason that the Government believes that calls for an independent NHS board, which would remove the NHS from meaningful democratic control, are misplaced. Moreover, the NHS has just come through a period of re-organisation. We do not believe this is the right time to impose further top-down change to structures. What matters more is that there should always be clarity and transparency about who takes what decisions on our behalf. That is the assurance that the Constitution will provide.

13. The Constitution improves accountability by making clear:

    - What individuals have a right to expect from the NHS

    - The principles by which decisions will be made

    - Who is responsible for what through a 'statement of accountability' to be published alongside the final version of the Constitution

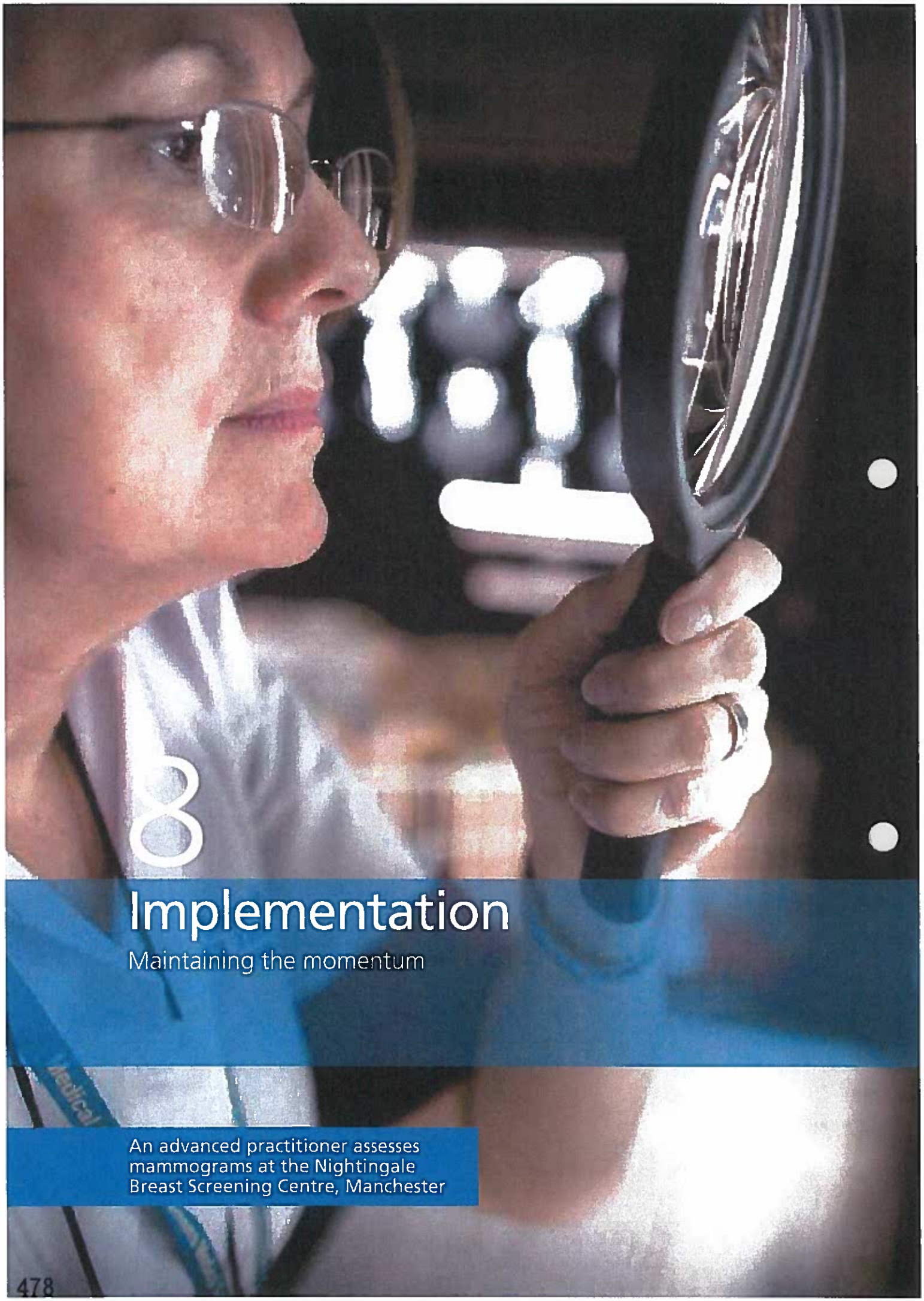
7

14. We encourage PCTs to experiment with how they can improve the way they give and take account of local views, within the current legislative framework. Many PCTs are already doing this, working with local communities and partner organisations to come up with governance arrangements that increase their responsiveness in a way that best fits their local needs:

Consultation process

15. The NHS belongs to us all. The Constitution is designed to reflect what matters, whether to patients, public or members of staff. It is therefore vital that the formal consultation builds on the process so far.

16. We will therefore create a Constitutional Advisory Forum that will bring together leading representatives from the patient, clinical and managerial communities, to oversee the consultation process. The Forum will work with the NHS to lead a process of engagement in every region of England, and report key messages back to the Secretary of State. It will be co-chaired by David Nicholson, the NHS Chief Executive, and Ivan Lewis, the sponsoring Minister.



8 Implementation

Maintaining the momentum

An advanced practitioner assesses mammograms at the Nightingale Breast Screening Centre, Manchester

8

Implementation

Maintaining the momentum

1. This Review has shown that there is enormous enthusiasm and energy throughout the NHS for achieving the vision set out in this report. The ambitious plans set out in every NHS region will be challenging to implement but in each case will improve services radically for patients.

2. I am keen that the pace should not drop. While change of this magnitude will not happen overnight, we should constantly strive to achieve high quality care for patients and the public. This chapter sets out how this will happen.

Leading local change

3. The Review as a whole has exemplified the process I believe will deliver these changes as effectively as possible. At its core has been the development of visions in every NHS region. We should now back local leaders – clinical and managerial – to deliver them.

4. I know that in each region, strategic health authorities (SHAs) are already working with primary care trusts (PCTs) to discuss proposals locally and ensure that the views of NHS staff, patients and the public are taken into account. In many cases change is already happening and patients are feeling the benefits.

5. By Spring 2009, each PCT will publish its strategic plan, setting out a five-year plan for improving the health of people locally. These plans will put into practice the evidence-based pathways of care at the heart of each region's vision. They will show a strong emphasis on partnership working between PCTs, local authorities and other partners (public, private and third sector – including social enterprise) to ensure that local health and wellbeing needs are better understood and addressed.

Enabling local change

6. Centrally, we will enable local improvements in three ways.

   - First, we will ensure that the funding is there to deliver the changes. The Department of Health will later this year make financial allocations to every PCT for the next two years. This will give PCTs clarity about the money they have to invest in improving the health of their populations.

   - Second, we will publish an NHS Operating Framework in October this year to set out the enabling system that will deliver this Review. Before then, the NHS Chief Executive and I will meet with staff across the NHS to discuss how to ensure this document best supports the delivery of PCT strategic plans.

8

- And third, we will ensure that, as the Department of Health develops the policy proposals described in this report (via legislation, where necessary), it does so in partnership with the NHS and stakeholders to ensure that the benefits we have all identified are fully realised. This will include Equality Impact Assessment wherever appropriate. Where a comprehensive evidence-base does not yet exist, we will also commission a programme of independent evaluation to improve learning and ensure transparency and public accountability.[106]

Conclusion

7. It has been a privilege to lead the NHS Next Stage Review. I am delighted that thousands of people have taken part in the process and have seized the opportunity to shape an NHS fit for the 21st century.

8. The priorities they have identified, together with the steps set out in this final report, represent an ambitious vision, one focused firmly on the highest quality of care for patients and the public. I challenge everyone who works in and with the NHS to deliver it for the benefit of this and future generations.

106 This will achieve the goal of a close dialogue between policy-makers and researchers advocated in N. Black. Evidence based policy: proceed with care. BMJ. 2001 Nov 17;323 (7322): 1187.

TSO

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone Fax & E-Mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries 0870 600 5522
Order through the Parliamentary Hotline Lo-Call 0845 7 023474
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone: 0870 240 3701

TSO Shops
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

The Parliamentary Bookshop
12 Bridge Street, Parliament Square,
London SW1A 2JX

TSO@Blackwell and other Accredited Agents

ISBN 978-0-10-174322-8

9 780101 743228

ACADEMY OF
MEDICAL ROYAL
COLLEGES

SEVEN DAY CONSULTANT PRESENT CARE

DECEMBER 2012

EXECUTIVE SUMMARY

The importance of consultants in providing high quality care for patients in hospital has been highlighted recently by the publication of *The Benefits of Consultant Delivered Care*[1]. This document recognises the significance of delivering the benefits identified in that report, seven days a week.

Currently, the availability of consultants varies widely by specialty and location in the evenings and at weekends. Many hospitals already have services in place to ensure that patients admitted in an emergency are seen by a consultant, or equivalent, within a few hours of their arrival in hospital. However, following the patient's transfer from the acute or admitting area of the hospital to a general ward, the provision for daily consultant review is considerably more limited.

Most hospitals and specialties already provide a non-resident consultant-led on-call rota, which should ensure that an acutely unwell or deteriorating patient has access to a consultant, and timely intervention. Physiological monitoring is becoming more sophisticated and linked to such escalation plans in some hospitals. However, in the absence of a daily 'planned' consultant review the remainder of the patient's care pathway is often put into hibernation particularly over weekends, resulting in delays in diagnosis, investigation, treatment and discharge from hospital.

The Academy of Medical Royal Colleges has developed three patient-centred standards to deliver consistent inpatient care irrespective of the day of the week. These standards reflect the importance of daily consultant review, and the consequent actions, to ensure progression of the patient's care pathway.

Standard 1: Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
Standard 2: Consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include interventions which will enable immediate discharge or a shortened length of hospital stay.
Standard 3: Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

Further detail on the rationale and practicalities of each of the three standards is given in the full report. Key points to note, that are all explained more fully in the body of the report, are:

- The method by which a consultant-led review takes place is likely to vary according to the local circumstances and specialty
- The consultant undertaking the review of the patient would be expected to have the necessary competencies to deal with the specific problems which the patient presents at the time of daily review
- It should be strongly emphasised that the standards should not be seen as detracting from existing or developing service standards in areas where even greater levels of consultant present care are required
- The Academy intends the term 'consultant' to include any doctor who is on the General Medical Council specialist register or certain senior doctors with appropriate competencies, to include those in Staff, Associate Specialist and Senior Specialty Doctor (SAS) grade posts and consultant clinical scientists.

The Academy does not see the three standards as a panacea for all patient safety issues, but as a strong contribution to improving parity and quality of patient care in all four countries of the UK. Whilst championing equitable, effective and excellent care for patients, the Academy recognises that the direct and indirect costs to implement these standards may be substantial and likely to have varying degrees of impact for service providers depending on their current levels of seven day consultant-present care. The Academy does not believe that the standards proposed in this report can be universally achieved within existing local resourcing arrangements and NHS tariff levels. Whilst full adoption of the standards may deliver some savings over time, it is not anticipated that they will be self-funding. Other interventions such as changes in working patterns and service reconfiguration onto fewer sites will be needed.

Local activity towards achievement of the standards can, and should, be made but there is also a need for a national level decision across all four countries in the UK on whether this patient safety initiative is to be supported and implementation resourced appropriately.

The Academy recognises that implementation of the standards will have different implications for different hospital specialties. Although some specialties already provide a seven day consultant presence which meets, or exceeds, these standards, for others the required changes will be considerable. The detail of how, and when, they will be implemented in each specialty is beyond the scope of this report. The Academy will coordinate a second document, during 2013, in which individual colleges and specialist societies will describe the implications for staffing, along with the resources, support services and timescales required to deliver the standards.

CONTENTS

1 INTRODUCTION

This report presents the Academy of Medical Royal College's (the Academy's) proposals for achieving parity for inpatient care throughout the week, in the light of evidence demonstrating less favourable patient outcomes at weekends compared to weekdays.

The report covers two main areas:

- Proposed standards for seven day consultant-present care in the delivery of inpatient care
- Consideration of the implications of the standards.

1.1 Background

In 2010, *Time for Training* recommended that a consultant-delivered service should be implemented and that 'consultants must be more directly responsible for the delivery of 24/7 care.'[2]

In 2011 the Dr Foster Hospital Guide[3] highlighted that patients are less likely to receive prompt treatment and more likely to die if they are admitted to hospital at the weekend. It also reported that the chances of survival are better in hospitals that have more senior doctors on site. Similarly, a report commissioned by NHS London in 2011[4] concluded that increasing cover by consultants in acute medical and surgical units at weekends could prevent more than 500 deaths a year in London alone.

In 2011, the Royal College of Surgeons England[5] produced standards for unscheduled surgical care. Recommendations included timely input of senior decision makers and a consultant-led service across all specialties.

In January 2012 the Academy published a report *The Benefits of Consultant Delivered Care*[1] which identified the following benefits of medical healthcare being delivered by consultant doctors:

- Rapid and appropriate decision making
- Improved safety, fewer errors
- Improved outcomes
- More efficient use of resources
- GP's access to the opinion of a fully trained doctor
- Patient expectation of access to appropriate and skilled clinicians and information
- Benefits for the supervised training of junior doctors.

The Department of Health has been concerned for some time about patient safety issues and promotion of greater access to services at evenings and weekends. NHS Improvement has been working with clinical teams across health and social care to identify examples of equality of treatment and outcome regardless of the day of the week. In February 2012 this work was published, giving implementation guidance and a number of case studies of seven day working service models across different clinical areas and levels of service.

Their case study pages demonstrate where extended working days or weeks have been successfully implemented to ensure that patients are able to readily access both acute, elective and re-enablement services across primary and secondary care. Further details of this can be read in the report *Equality for all: Delivering safe care – seven days a week.*[6]

In March 2012, the National Institute for Clinical Excellence (NICE) announced 123 new quality standards that they would be developing. One of which will be a Seven Day Working Service Standard. Academy representatives will be joining the development group for this standard, which is expected to be published in 2013.[7]

In April 2012 the Royal College of Paediatrics and Child Health published *Consultant Delivered Care – an evaluation of new ways of working in paediatrics.*[8] This six-month project carried out a survey of all paediatric inpatient and neonatal trusts in the UK to look at the extent to which consultant-delivered care models are already being used. Based on the results of this survey, in-depth site visits were conducted at ten trusts to look at how these ways of working impacted team members, resident consultants and a range of indicators. The report concludes that children would receive better care if they had 24/7 access to a consultant or equivalent senior doctor.

In September 2012, the Royal College of Obstetricians and Gynaecologists published its report *Tomorrow's Specialist*[9]. The report notes that *'tomorrow's specialists will work differently: in teams with peers, providing on-site care 24 hours a day, 7 days a week, in non-hospital settings, as 'localised where possible, centralised where necessary' becomes the norm'*. The report emphasises that the trend towards increased consultant-delivered care must continue so that more consultants are employed to provide care 24 hours a day, seven days a week.

In October 2012, the fourth in the series of acute care toolkits from the Royal College of Physicians of London (RCPL) was produced in collaboration with the Society for Acute Medicine (SAM). The toolkit provides practical guidance for hospitals to enable the delivery of a consultant presence on the Acute Medical Unit for a minimum of 12 hours a day, seven days a week.[10]

Also in October 2012, the RCPL and Royal College of Nursing issued a joint statement[11] calling for ward rounds to be made the cornerstone of patient care, and for a 'concerted culture change' with clinical staff, managers and hospital executives engaging with, and focusing on, improving the quality of ward rounds.

The RCPL is currently undertaking a project, the Future Hospital Commission (FHC)[12] to review all aspects of the design and delivery of inpatient hospital care. The FHC aims to address growing concerns about the standards of care currently seen in hospitals and to make recommendations to provide patients with the safe, high-quality, sustainable care that they deserve.

The project, due to complete in 2013, will examine organisational structures processes and standards of care, focusing on five key areas:

- Patients and compassion
- Place and process
- People
- Data for improvement
- Planning infrastructure.

The Academy's Seven Day Consultant-Present Care project has maintained close links with the FHC as the FHC wishes to ensure that its own recommendations complement and support the Academy project outcomes. It should be noted, however, that the Academy project applies to all specialties and all four nations – the FHC scope relates only to Internal Medicine in England and Wales.

The Royal College of Radiologists (RCR) is working on chemotherapy components of care through the National Chemotherapy Implementation Group (NCIG) and also the RCPL (through the Joint Collegiate Council for Oncology). For Radiotherapy, the RCR is working with the National Radiotherapy Implementation Group to look at the most effective patterns of service delivery to fulfil seven day and extended hours working.

In June 2012, the National Institute of Health Research issued a commissioned call for research projects examining the organisation and delivery of 24/7 healthcare under their Health Services and Delivery Research programme.[13]

The Health Foundation Flow Cost Quality Programme,[14] due to formally report late 2012, is looking at the emerging relationship between poorly managed patient care pathways through a hospital and the wider healthcare system and the outcomes of care as measured by a hospital's standardised mortality rate (HSMR). Early learning from the programme has found a persistent mismatch between the predictable variations in emergency demand and the availability of workforce capacity. At one site, two-thirds of the daily demand had to be 'stored' overnight during weekdays and reworked on subsequent days, wasting resources and causing stress to staff and patients. At weekends, two days' worth of patients had to be 'stored' until Monday. Mapping a patient's journey revealed that 83% of the resources were wasted in this way. The situation was worse during public holidays.

A more detailed literature review is contained in Appendix B illustrating the growing number studies suggesting that mortality rates are higher for patients admitted to hospital in the evenings and at weekends.

1.2 Project Rationale and Aims

The project builds on the Academy's *The Benefits of Consultant Delivered Care*[1] report. If the medical profession accepts that consultant-delivered care provides better patient outcomes, it would seem ethically unjustifiable to deprive patients of those benefits during the weekend. The Academy instigated the Seven Day Consultant-Present Care project to make recommendations to deliver a consistent high quality of care for patients in hospital across the whole week, for all specialties. The Academy sub-group took the view that this was best conceptualised in terms of generic patient care pathways rather than proposing specialty-specific consultant rotas, and should be focussed on developing patient-centred standards based on the principle of daily consultant review.

1.3 Terminology

The Academy recognises that the use of the term 'consultant' itself potentially causes difficulties. Equally the term 'fully trained' implies that learning and development is complete which will not be the case.

In this document the term consultant refers to those hospital doctors who have either a Certificate of Completion of Training (CCT) or Certificate of Eligibility for Specialist Registration (CESR) and are thus eligible to be on the General Medical Council (GMC) Specialist Register, or certain senior doctors with appropriate competencies, to include those in Staff, Associate Specialist and Senior Specialty Doctor (SAS) grade posts. The term 'consultant' is being used because it is believed that this is a term broadly understood by doctors and the public.

However, the term 'consultant' is not meant to be synonymous with the current terms and conditions of the consultant contract. The pay and career structure for post-CCT doctors should be considered separately from issues relating to the benefit, or otherwise, of care being primarily delivered by consultants.

It is also important to state that the Academy is not suggesting that it should only be consultants who deliver medical care. The Academy recognises and supports the principle that successful care is based on a team approach where a range of healthcare professionals contribute to the delivery of a successful patient outcome. Staff, Associate Specialist and Senior Specialty (SAS) doctors, trainee doctors, nurses, allied healthcare and healthcare science professionals, clerical and administrative staff also play a fundamental role in the provision of care.

2 METHOD

The Academy established a steering group in April 2012 with representatives from all medical Royal Colleges, led by Professor Norman Williams (President of the Royal College of Surgeons England) to oversee the project. From this a sub-group was convened, with members representing the specialties considered most likely to be impacted. Members of the steering group and sub-group are listed in Appendix A.

The project had three distinct phases:

1) A call for information from medical Royal Colleges specifically asking for:
   - Current initiatives in seven day consultant-present care in their specialty
   - Views on the most appropriate level of consultant-present care for their specialty
   - The equivalent level of input they expected from other specialties and supporting services.

2) A literature review of current evidence and information on seven day consultant-present care. This drew on a diverse literature encompassing weekend versus weekday mortality and adverse events, patient safety, daily effects on outcome in specific diseases, medical rotas and staffing, fatigue and burnout, workforce, and emergency care.

3) Consideration of all the evidence in order to develop a common position on how to ensure parity of quality of care for inpatients across the whole week.

3 RESULTS

The Academy collated information from each medical Royal College on their current approach to seven day consultant presence (summarised in Appendix C). This varies between specialties, and unsurprisingly shows that those involved in acute and emergency care have more advanced guidance or position statements relating to levels of consultant presence.

Colleges were also asked which specialties they considered should have consultant-presence seven days a week and these are listed below:

- Anaesthetics
- Intensive Care Medicine
- Emergency Medicine
- General Practice*
- Obstetrics and Gynaecology
- Paediatrics
- Chemical Pathology
- Histopathology
- Medical Microbiology
- Medical Virology
- Acute Internal Medicine
- Cardiology
- Clinical Pharmacology and Therapeutics
- Gastroenterology
- General Internal Medicine
- Geriatric Medicine
- Haematology
- Infectious Diseases
- Medical Ophthalmology
- Neurology
- Renal Medicine (Nephrology)
- Respiratory Medicine (Thoracic Medicine)
- Rheumatology
- Stroke Medicine
- Cardio-thoracic Surgery
- General Surgery
- Neurosurgery
- Trauma and Orthopaedic Surgery
- Child and Adolescent Psychiatry
- General Psychiatry
- Clinical/Diagnostic Radiology
- Clinical Oncology (Radiotherapy)

* *Whilst General Practice falls largely outside the scope of this report, which focuses on inpatient care, responses from the medical Royal Colleges acknowledged the importance of GP availability seven days a week to ensure inter-professional liaison and patient transfer between the hospital and community.*

4 PROPOSED STANDARDS AND PRINCIPLES

The standards proposed by the working party are rooted in the concept of the patient care pathway and rest on the following basic principles:

- Consultants 'add value' through diagnosis (choosing the correct care pathway) and ensuring timely transit along that pathway (investigations, treatment and destination)
- Other pathway components must also be optimally configured, including the supporting clinical team, diagnostic and therapeutic services, administrative and clerical support, and community care at discharge.

Currently the availability of consultants varies widely by specialty and location, particularly in the evenings and at weekends. For emergency admissions, patients are generally seen by a consultant within a few hours of their arrival. However, following discharge from acute areas to general wards the frequency of consultant review falls significantly. The result is that departures from the care pathway are not uncommon, and are not detected in a timely manner. While physiological monitoring is becoming more sophisticated and linked to escalation plans in some hospitals, the rest of the care pathway is often put into hibernation, particularly over weekends, resulting in delays in diagnosis, treatment and discharge decisions.

The working party has proposed three standards:

Standard 1: Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.
Standard 2: Consultant-supervised interventions and investigations along with reports should be provided seven days a week if the results will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include interventions which will enable immediate discharge or a shortened length of hospital stay.
Standard 3: Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

4.1 Standard 1

Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

What this means in practice is that the status of every inpatient whose care pathway would be altered by daily consultant-led review should be considered at least once in every twenty-four hour period to check five elements:

- Physiological safety
- Diagnosis and correct treatment
- Timely investigations
- Clear communication with patient and colleagues
- Discharge planning.

This is distinct from the need to provide 24 hour consultant-led intervention for patients whose clinical condition requires this. Existing out-of-hours consultant on-call rotas in the acute setting lie outside the scope of this standard.

4.1.1 Rationale

Admission to hospital can be categorised as planned or unplanned. Planned admissions are those where the patient requires a scheduled procedure or investigation which cannot be performed in an outpatient or primary care setting. Unplanned admissions may be driven by unexpected changes in a person's health requiring urgent or emergency assessment, monitoring, investigation and treatment. Whatever the reason for admission, the patient's on-going treatment is defined according to a care pathway which depends on the nature of the problem and the patient's response to treatment.

Following unplanned hospital admission there is often an initial period of uncertainty while a diagnosis is being made. During this period the patient may be physiologically unstable, requiring close monitoring, repeated assessment and appropriate intervention. The importance of consultant involvement during this period has been highlighted in a number of reports, and guidelines have been produced recommending early consultant review for all patients in this setting, seven days a week.[15,10]

The mechanisms to ensure that seven day consultant-led care, is provided for patients after this initial 24 hour period are often less robust. Early Warning Scoring systems may trigger the need for senior clinical review of patients who are physiologically unstable. However, it is not uncommon for patients whose condition is not deteriorating to wait until the next scheduled weekday review before being seen by a consultant. For example, a patient who is admitted on a Thursday night will usually be seen by a consultant on Friday morning, but may then wait until Monday for their next scheduled consultant review. The wait may be even more prolonged for patients admitted during or prior to a Bank Holiday weekend.

During the period between consultant reviews there may be considerable changes in a patient's condition. Daily consultant-led review could result in earlier recognition of deterioration in a patient's condition, or identify a diagnosis that was not apparent at the time of the initial consultant review. Recognition of improvement in a patient's condition could also result in earlier discharge from hospital.

4.1.2 Practicalities

Current systems usually require that clinical teams identify specific patients who would benefit from consultant-led reviews over the weekend, with the presumption that other patients can wait until the next normal working day for review.

The standard therefore represents a shift from the current usual working practice of 'opting-in', to a system where all patients are assumed to need a daily consultant-led review unless it is specified that this is *not* required. Standard 1 is therefore an 'opt-out' system, in which the default position is daily consultant review.

The method by which a consultant-led review takes place need not be constrained to formal, physical bed-side ward rounds by a consultant. Other appropriate methods of consultant-led review could include:

- Ward round undertaken by a doctor in training or SAS doctor, followed by a discussion of all, and review of selected, patients by the consultant
- A multi-disciplinary team 'board-based' round.

Physical presence of the consultant in the clinical environment is a key component of this recommendation, so that issues arising from the daily review can be identified and appropriate actions instigated without delay.

There may be some inpatients whose care pathway is not likely to be influenced by a daily consultant-led review. These will often be patients who have already been in hospital for a number of days, whose clinical condition has remained stable and whose expected date of discharge is not imminent. Additionally, some care pathways include discharge criteria which permit discharge without further consultant-led review. This effective use of the skills and experience of a multi-disciplinary team should be preserved.

Specialties will need to develop robust mechanisms to identify those patients for whom consultant-led review is not likely to influence the patient's care pathway; it is recognised that this will be particularly important for those specialties with large numbers of inpatients whose care pathways progress relatively slowly (e.g. Internal Medicine and Medicine for the Elderly). The mechanisms whereby this process is developed will be described in the follow up report, to be published during 2013.

Mechanisms should be in place to ensure that a daily consultant-led review can be re-instated, if required, due to a change in the patient's condition. It should also be recognised that some patients will require consultant-led review more than once in every 24 hour period.

Defining minimum standards for consultant-led care for inpatients will allow hospitals to determine the consultant staffing levels required in each specialty. Specialties which involve significant procedural activity in addition to ward-based inpatient care may require these duties to be separated. For example, a surgical service may require one consultant to be in theatre, while another consultant leads inpatient reviews.

The duration of a consultant-led review will vary according to the patient's needs, but will also be influenced by the nature and size of the supporting clinical team. Optimum use of the consultant time will be achieved if the consultant is on-site, leading a team comprising doctors in training, SAS grade doctors, nurses and allied healthcare professionals supported in the clinical areas by adequate administrative and clerical staff.

Efficient use of consultant time may also be improved by adopting working practices which support continuity of care. The time taken to review a patient will be considerably shortened if the consultant has been previously involved with their care.

Increasing the frequency of consultant-led review is likely to increase the number of consultants involved in the care of any one patient. Development of working practices to optimise continuity are essential, along with effective consultant to consultant handover. The Academy acknowledges the potential challenges of specialist versus generalist consultant review. These challenges will vary according to the specific needs of the patient and the make-up of the workforce, including those on flexible working patterns but should not detract from the Academy's overall view that application of Standard 1 will result in higher quality patient care.

4.2 Standard 2

Consultant-supervised interventions and investigations along with reports should be provided seven days a week if they will change the outcome or status of the patient's care pathway before the next 'normal' working day. This should include interventions and investigations which will enable immediate discharge or a shortened length of hospital stay.

What this means in practice is that the progress of a patient along their care pathway should not be delayed because investigations or interventions are not available on certain days of the week. While the delivery of the intervention or investigation may be delegated to any appropriately trained and competent clinician, the overall provision of the service should be supervised by a consultant.

4.2.1 Rationale

Most hospitals currently provide seven day access to investigations and other interventions when a patient's life may be at risk, or to prevent an imminent deterioration in their condition. However, the same level of service may be required in less urgent circumstances in order to facilitate progression of the patient's care pathway. This may result in a change in diagnosis, alteration in treatment or an earlier discharge from hospital.

Provision of appropriate investigations and interventions is essential to ensure that the maximum benefit of daily consultant-led review is realised.

The investigations and interventions required will vary according to the patient's specialty problem, and this will be defined more explicitly in the second stage of this report, due for publication in 2013. However, it is likely that this will include the provision of radiological services (including cross sectional imaging and ultrasound), non-invasive cardiological investigations, endoscopic procedures and laboratory services.

Consultant-supervised interventions should also include the provision of specialist advice, wherever possible, seven days a week.

4.2.2 Practicalities

It is difficult to quantify the impact of implementation of Standard 2. While the overall number of investigations and interventions should not increase, an increased number of these may be undertaken at weekends which may require significant reorganisation of services and personnel.

It is possible that the overall number of interventions may fall as daily consultant-led review leads to the selection of more appropriate tests, first time.

The impact of this standard will need to be evaluated in hospitals of different sizes and configurations, and will vary across different specialties.

4.3 Standard 3

Support services both in hospitals and in the primary care setting in the community should be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

As with Standard 2, this means that the progress of a patient along their care pathway should not be delayed because a support service, either in hospital or in the community, is not available on certain days of the week. This includes the ability to ensure safe discharge from hospital.

4.3.1 Rationale

Many specialties rely heavily on the contribution of a hospital-based multi-professional team to enable the patient to progress along their care pathway. Specialist nurses, physiotherapists, occupational therapists, social workers, pharmacists, speech and language therapists, dieticians and other healthcare professionals provide a key role for many patients, including those recovering from surgery and medical patients with complex needs.

Ensuring that key staff are available to provide appropriate interventions will be crucial if the full benefit of seven day consultant presence is to be realised. Such interventions should include those designed to expedite hospital discharge as well as those required to prevent deterioration in patients with more critical illness. The need to access patient records should also be recognised.

For surgical specialties, access to a fully staffed operating theatre to enable provision of appropriate interventions as defined by the consultant-led review will also be a requirement.

Close liaison with community teams is an essential component of safe discharge from hospital. Difficulties in ensuring continuity of care following discharge from hospital at a weekend may currently result in delays in discharge, and increase the likelihood of early readmission. Provision of appropriate support staff in the community is therefore important to optimise the benefit of daily consultant-led review.

For some patients, progression of the care pathway may benefit from direct communication between the consultant and general practitioner (GP). Current arrangements for out-of-hours primary care at weekends do not facilitate such direct communication.

Given that general practitioners provide the equivalent of 'consultant-present care' for patients in the community, the provision of direct 'consultant-to-GP' handover for selected patients at weekends would help to ensure that they remain on the appropriate care pathway after discharge from hospital.

4.3.2 Practicalities

In many cases the availability of services in the community at a weekend is a major limiting factor in the discharge process. Although the NHS provides a seven day out-of-hours service for patients becoming unwell at a weekend in the community, there may be times when discharge could occur if adequate nursing and social care could be started on a weekend day, and in some complex cases a medical review may be needed within 48 hours of discharge. Difficulties in ensuring the appropriate 'safety net' to allow discharge of a patient with more complex needs may result in this discharge being delayed.

General Practitioners provide the equivalent of consultant-present care for their patients. Although this project has not specifically looked at reconfiguration of primary care, further consideration needs to be given to how 'consultant to consultant handover' can be provided out of hours where there are patients for whom ongoing daily review would help to ensure that they make an effective transfer back into the community. The Academy recognises this is an issue to be addressed.

5 IMPACT ASSESSMENT OF THE STANDARDS

5.1 Benefits

Providing consultant-present care, seven days a week and implementing these standards should strengthen the benefits identified in *The Benefits of Consultant Delivered Care*[1]. The subheadings in this section reflect the potential benefits identified in that document.

Greater parity of care across a seven day week

By setting a standard of care that is irrespective of the day of the week, patients should receive a quality of care dictated by the status of their health, not by the working pattern of their healthcare providers.

High level of clinical competence ensuring rapid and appropriate decision making

The standards provide the opportunity at least once in every 24 hours to confirm that the patient is on the most appropriate care pathway and to ensure that progress along the care pathway is not delayed on certain days day of the week.

Improved outcomes for patients which follow from timely diagnosis and clinically skilled interventions

Additional evidence of benefits to patient outcomes has been collected since the Academy's *The Benefits of Consultant Delivered Care*[1] Report published in January 2012. The Royal College of Physicians report, An evaluation of consultant input into acute medical admissions management in England[16] found that *'Hospitals where the admitting consultant was present for more than four hours for seven days a week had a lower 28 day readmission rate.'*

Skilled judgement and performance leading to the most effective working and more efficient use of resources

Daily consultant-led reviews of patients, combined with appropriate support services irrespective of the day of the week allows for discharge decisions to be made without the pressure of considering the proximity of the weekend. This could reduce the risk of discharge taking place too early or delays to discharge. The experience of the consultant should ensure that, whilst the numbers of investigations may increase during the weekend by providing parity of service, unnecessary workload should be minimised.

GP's access to the opinion of a fully trained doctor

Seven day consultant presence will mean easier weekend access for GPs needing a consultant's opinion. Similarly, full implementation of Standard 3 would increase weekend access to informed primary care clinicians for consultants.

Training opportunities for the benefit of junior doctors

Greater levels of consultant presence over a seven day week provides more opportunity for consultant supervision of trainee doctors. The recent Royal College of Paediatrics and Child Health review into consultant-present care noted greater trainee satisfaction where consultants were present seven days a week.[8]

Meeting patient expectation for appropriate and skilled clinicians and information in a timely fashion

Patients expect treatment by competent clinicians and a parity of care irrespective of the day of the week. The Department of Health is also keen that patients make choices about when they receive healthcare and there is a general drive to ensure patients feel involved and in control of their treatment.

While the standards in this report are not directly looking to make elective services more widely available, implementing the resourcing and working practices to meet the standards may indirectly enable healthcare providers to increase provision of weekend elective care in future.

5.2 Implementation implications

5.2.1 Impact on Consultant Workforce

A variety of factors may impact on the required number of additional weekend and weekday consultant hours to deliver these standards. These may include: the current frequency of consultant-led review, the numbers of patients deemed not to require daily consultant-led review and the duration of each consultant-led review.

The specific workforce implications for each specialty will vary considerably, and will be dealt with more specifically in the second report of this project, due for publication later in 2013.

5.2.2 Demand on investigation and intervention specialties and support services

It is anticipated that Standards 2 and 3 should largely level out demand for investigation, intervention and support services over a seven day week, rather than creating new demand. However, the overall impact is unknown and will need to be carefully evaluated to ensure appropriate allocation of resources.

Provision of certain investigations and interventions at weekends may require that a patient is transferred to a different hospital. This will have implications for ambulance services and other staff involved in the transfer process which will need to be considered.

5.2.3 Addressing the implementation implications

In aspiring to achieve the highest possible quality of care for patients, the Academy believes that the standards set out in this report describe the 'right thing to do'. The Academy does not see the three standards as a panacea for all patient safety issues, but as a strong contribution to improving parity and quality of patient care. It should be strongly emphasised that the standards should not detract from existing or developing service standards in areas where even greater levels of consultant-present care are required. For example the Royal College of Obstetricians and Gynaecologists has recommended development of a 24-hour consultant

presence in the majority of obstetric and acute gynaecology units; the Royal College of Physicians recommends twice daily consultant review for all patients on the Acute Medical Unit, seven days a week; the Faculty of Intensive Care Medicine recommends daily consultant-led ward rounds seven days a week with consultant review within 12 hours of admission and the Royal College of Paediatrics and Child Health are developing specific standards for paediatric consultant availability.

The standards do not imply that consultants do not already work across all the days of the week, and the Academy is aware that all hospital patients already have the 'safety net' of 24/7 emergency on-call arrangements. Seven day consultant-present care is already provided in most Emergency Departments, Acute Medical Units, Intensive Care Units, many acute surgical specialties, and obstetrics.

In delivering the patient safety benefits of consultant-present care, there should be associated improvements in productivity, with the right care being given at the right time. The Centre for Workforce Intelligence (CfWI) commented that the number of consultant appointments has not kept pace with the number completing specialist training; with increasing numbers of CCT holders taking up SAS roles the number of trained doctors available to deliver these standards may be greater than would be apparent, if focussing only on those in existing consultant posts.[17]

The Academy also recognises that the direct and indirect costs to implement these standards may be substantial and likely to impact service providers, dependent on their current levels of seven day consultant presence. Robust workforce implications require systematic modelling that is outside the scope of this report, and will differ depending on patient and specialty related variables. The Academy does not believe that the standards proposed in this report can be universally achieved within existing funding and NHS tariff levels. In addition, it is likely that service reconfiguration onto fewer sites will be needed. Whilst full adoption of the standards may deliver some savings over time, it is not anticipated that they will be self-funding. Local activity towards achievement of the standards can, and should, be made but there is also a need for a national level strategic decision across all four countries in the UK.

Meeting the implementation challenge is unlikely to be achieved through a 'one size fits all' solution. Depending on the circumstances of the individual service provider, a combination of approaches may prove most appropriate. Bearing that in mind the Academy suggests that the following local and national work force planning issues should be considered in implementing the standards.

The most efficient use of consultants' time should be ensured by:

- Reviewing the levels of consultant presence required across each 24 hour period
- Matching skills to roles, and considering the appropriate resource mix for a team
- Considering local organisational and process changes, such as 'slow-stream' and 'fast-stream' wards and encouraging discharge-planning from the point of admittance
- Remodelling theatre resource allocation, or considering use of 'hot clinics' in order to increase emergency theatre access. If emergency operating is concentrated in daily lists, with trauma and general emergencies separated, this can allow concentration of expertise at key times.

Local service providers could also consider a phased approach to the implementation of the standards. For example, priority could be afforded to those patients judged to benefit most from a daily consultant-led review until resources are sufficient to enable full implementation of Standard 1. In this context, patients transferred from acute areas in the preceding 24 hours should be considered a high priority for consultant-led review.

An initial prioritisation of investigations and interventions may also need to be considered, for example giving a higher priority to those that might lead to a more immediate change of treatment or outcome, pending full implementation of Standard 2.

Implementing these standards also needs to be considered in the wider context of large-scale service reconfiguration. Regionalisation and concentration of acute services in a smaller number of centres may be needed to maximise quality and improve efficiency and productivity. The Royal College of Physicians' Future Hospital Commission[12] is also evaluating different models of acute care consultant provision in hospitals. Reconfiguration decisions would need to consider impact on areas such as transport and transfer services; this will be dealt with in more detail in the following document to this report, later in 2013.

Efficiency gains elsewhere in service delivery might contribute to the ability to increase consultant hours for patient review and seven day investigation, intervention and support services. The joint NHS Confederation, BMA, JMCC and Academy Report Clinical Responses to the Downturn[18] contains ideas developed by clinicians, for efficiencies and productivity gains within the areas of: Neurosurgery; Elderly Care; Vascular Services; Pathology; Orthopaedics; Neonatology and Dermatology.

There may be potential to off-set some of the set-up costs for implementing a seven day standard for a consultant-led review and seven day supporting services against any activity a local service provider may be considering or undertaking to provide income generating, elective services seven days a week.

6 NEXT STEPS

As noted previously this report follows on from the publication of the *The Benefits of Consultant Delivered Care*[1] by identifying standards to enable consultant-present care regardless of the day of the week.

The Academy will begin work in 2013 with individual Royal Colleges and Specialist Advisory Boards to determine the likely implications of implementation of these standards for each hospital specialty. This will include examination of changes to the consultant workforce for each specialty, the necessary support services and the likely timescale.

The Academy is also now looking to work with the NHS Commissioning Board (to include in annual appraisal criteria for primary care services), Health & Social Well-being Boards, NHS Employers as well as individual service provider organisations so that the standards can be supported and included in future service work force planning. The Academy also hopes that these standards will be used to inform other seven day standard initiatives being developed by organisations such as NICE. Systematic evaluation of the standards is also required, within a research framework.

APPENDIX A
MEMBERSHIP OF THE ACADEMY STEERING GROUP

Professor Norman Williams, Steering Group Chair
President, Royal College of Surgeons of England

Dr Chris Roseveare, Sub-Group Co-Chair **
Royal College of Physicians London and President of Society for Acute Medicine

Professor Julian Bion, Sub-Group Co-Chair **
Dean Faculty of Intensive Care Medicine

Dr Vimo Arumuham
Academy Trainee Doctors Group representative

Dr Sue Barter
Royal College of Radiologists

Dr Blandina Blackburn
Faculty of Occupational Medicine

Dr Peter Blakeman **
Royal College of Obstetricians and Gynaecologists

Mr Richard Bryant
Royal College of Anaesthetists

Dr Hilary Cass
Royal College of Paediatrics and Child Health

Mr Tim Dabbs **
Royal College of Ophthalmologists

Mr Bob Diament
Royal College of Surgeons of Edinburgh

Mr Bob Greatorex **
Royal College of Surgeons of England

Mr Steve Griffin**
NHS Employers

Mr Alastair Henderson **
Academy of Medical Royal Colleges

Professor Amanda Howe
Royal College of General Practitioners

Dr Hywel Jones
Royal College of Anaesthetists

Dr Mike Jones **
Royal College of Physicians of Edinburgh

Dr Terry Jones
Royal College of Pathologists

Dr Liz Junor
Royal College of Radiologists

Dr Nick Kosky
Royal College of Psychiatrists

Dr Cliff Mann **
College of Emergency Medicine

Mrs Scarlett McNally
Academy Staff and Associate Specialist and Specialty Doctors Committee representative

Dr Robin Northcote
Royal College of Physicians and Surgeons of Glasgow

Mr Dermot O'Riordan **
Royal College of Surgeons of England

Dr Linda Patterson
Royal College of Physicians London

Dr Nigel Penfold
Royal College of Anaesthetists

Dr Shirley Rigby
Royal College of Physicians London

Dr Damian Roland
Academy Trainees Doctors Group

Ms Carol Sheppard **
Academy of Medical Royal Colleges

Dr Nicola Strickland **
Royal College of Radiologists

Significant additional assistance provided by:
Ms Gemma Cantelo, Royal College of Physicians, London and Miss Rosie Carlow, Academy of Medical Royal Colleges.

*** Indicates member of the sub group*

APPENDIX B
SEVEN DAY CONSULTANT PRESENT CARE - LITERATURE REVIEW

October 2012

Evidence that weekends are 'dangerous'
There is a growing body of evidence that case mix-adjusted mortality rates are higher for patients admitted electively or as emergencies to hospital 'out-of-hours', with most research focussing on weekends [Freemantle 2012, Mohammed 2012, Cram 2004, Cavallazzi 2010, Aylin 2010, Kruse 2011, Buckley 2012, MaGaughey 2007, James 2010, Worni 2012, De Cordova 2012, Deshmukh 2012]. The size of the weekend effect lies between 0.2% and 1% absolute increase in crude mortality over all admissions, detectable with large populations but not large enough to use mortality as an end-point in interventional studies.

Not all studies report a positive association however [Byun 2012; Kazley 2010; Kevin 2010; Myers 2009]. One recent publication has demonstrated that the 'weekend effect' is more marked for elective admissions than for emergency admissions [Mohammed 2012]; a potential explanation requiring further investigation is incomplete adjustment for case mix of weekend elective admissions, with patients with complex and comorbid disease being more likely to be admitted well in advance of surgery for investigation and stabilisation.

The rational for seven day working: Unreliable care and poor process control contribute to the 'weekend effect'.
Factors contributing to increased mortality may include inadequate numbers of skilled staff [Kane 2007, Cho 2008, Kane 2007, Needleman 2002, Pronovost 2002, Wallace 2012, Kim 2010, Aiken 2002, Penoyer 2010], healthcare error and adverse events [Hogan, Vlayen, Buckley], lack of organisation and structure for care delivery [Anderson], and reduced access to specific interventions [Kostis, Deshmukh]. In the RCP consultants' survey [RCP 2010] only 19% of responding hospitals reported having a formalised acute response team for acutely ill patients.

A single formal ward round was conducted in Acute Medical Units (AMUs) at weekends in 29% of hospitals, and two or more formal rounds in 69%. However, only 20% of consultants were available at weekends for periods exceeding 8 hours, and 18% reported no weekend attendance at hospital, while 73% of acute physicians did not work at weekends. Only 39% of consultants working in acute medical units reported having protected time for this work free of other duties, and providing care for blocks of time greater than a single day. The largest gap in terms of consultant input (and in reliable information on current practice) would appear to be in the care of patients following their discharge from the AMU for continuing care on ordinary wards.

Unreliable delivery of best practice care is a major public health problem for all health systems, characterised by the classic McGlynn paper [McGlynn NEJM 2003] now replicated with similar results in Australia [Runciman MJA 2012]. Adverse event rates are increased at weekends with a reported weekend-weekday incident ratio of 2.74 [Buckley 2012]. One example of the consequences of unreliable care is unplanned admission to intensive care, which is commonly preceded by errors in clinical management [McQuillan 1998, Braithwaite 2004, Vlayen 2011], and which is also associated with hospital admission at nights and weekends [Tam 2008]. In an examination of the case records of patients suffering surgical complications or death, the reviewers found that the majority could be attributed to poorly organised care, particularly failures in critical thinking or undisciplined treatment strategies [Anderson 2012]. Gaps and discontinuities in care make this worse; in the Royal College of Physicians consultant survey, 28% reported that they considered continuity of care to be poor in their own hospital [RCP London 2012].

Contrary to expectations, elective hospital admissions may be more susceptible to error than emergency admissions [Hogan 2012], an unexpected finding which parallels the observation [Mohammed 2012] that elective admissions at weekends have a higher case mix-adjusted mortality rate than emergency admissions. Hogan et al [Hogan 2012] also reported that errors were more likely in patients without severe health impairment, again suggesting that when patients are identified as being high risk, the system is capable of responding appropriately, but may then miss those patients perceived as being low risk. The main errors associated with preventable deaths in Hogan's study included poor clinical monitoring, diagnostic errors, and inadequate drug or fluid management.

It is possible therefore that what makes the difference between weekend and weekday care, between a complicated and an uncomplicated clinical course, is the track or pathway on which the patient is travelling. Elective admissions in an emergency environment do no better than emergency admissions in an elective environment, because neither is on the right rails, and both are therefore susceptible to gaps and discontinuities in care. However, while the 'weekend effect' may not be more important for the acutely ill patient than for patients admitted electively to hospital, the acutely ill patient does present special challenges for the healthcare system in terms of volume, risk, cost, and competition for elective pathways.

The acutely ill patient is a major challenge for health services

Acutely ill patients are not usually perceived as a coherent group because of the traditional disease-specific compartmentalisation of specialist practice, but they present a major challenge to healthcare in terms of volume, risk, safety, costs, and impact on elective care pathways. In 2008-9 there were 5M emergency admissions to hospitals in England, a rise of 11.8% since 2004/5, and representing 35% of all hospital admissions [Blunt 2010]. This has increased to 5.2M emergency admissions for 2010 and 2011 [Monthly HES data]. HES data for 2009-10 analysed in the survey by the Royal College of

Physicians [Lambourne 2012] identified 1.3M emergency discharges from acute hospitals in England, with a mean (range) per hospital of 13,550 admissions (5,479-56,853) (reproduced in Table 1).

Emergency admissions are estimated to cost the NHS around £11Bn per year [Blunt 2010]. Given the additional (unquantified) numbers of elective hospital admissions who develop complications during their hospital stay requiring urgent or enhanced levels of care (such as admission to intensive care units), the acutely ill patient population is the single largest group of patients in the NHS.

Acutely ill patients represent a high-risk population

The mortality rate at hospital discharge or 30 days is 0.7% for elective hospital admissions but 3.6% for emergency admissions, with a palliative care diagnosis being coded in only 17.2% of admissions who died (overall, 1%) [HES data 2011]. Mortality risk is much higher for specific conditions such as myocardial infarction (32%) [Smolina BMJ 2012], stroke (around 20%) [McKinney 2011], fractured proximal femur (10%) [Wu 2011], and septic shock (30-40%) [Levy 2010].

Prevention: linking interventions to outcomes in complex systems

Although there is a clear association between suboptimal healthcare organisation and outcome, a causative link between diverse interventions and improvements in care is much less obvious. Several studies demonstrate that behavioural interventions to improve reliability of delivery of best practice may have imperceptible effects on care processes even though outcomes improve over time [Benning 2011; Benning 2011; Matching Michigan Collaboration 2012]. The scope for preventing errors leading to adverse outcomes may be limited, with estimated preventability rates of only 5-6% [Hayward &Hofer 2001, Hogan 2012], though others report higher preventability rates for errors which precede ICU admission [Vlayen 2011]. It is also notable that systems-level interventions designed to facilitate earlier intervention in patients at risk of deterioration, including medical emergency teams or outreach [McGaughey 2007] and 'hospital at night' interventions [Hospital at Night 2010] have been unable to identify strong evidence of effectiveness, but these interventions are specifically designed to work-around the lack of consultant input on wards or out-of-hours.

This lack of apparent impact on outcomes might be real, or a sample size effect, or because systems-level interventions do not distinguish the content of the intervention from the delivery device, or the effect may be confounded by the context in which these interventions are placed. For example, night-time intensivist staffing is associated with reduced case mix-adjusted mortality, but only in ICUs with low-intensity intensivist staffing during the day, [Wallace 2012], suggesting that there may be an optimal dose-response effect in relation to other contextual factors.

A recently reported 8-week block cross-over pilot study in two Canadian ICUs staffed by intensivists has reported that resident night-time intensivist staffing was not associated with detectable improvements in patient outcomes or family satisfaction, but was associated with less burnout symptoms amongst the intensive care specialists and with more role conflict reported by the nursing staff [Garland 2012]. A five-ICU four-hospital study from the USA has reported that an intensivist two-week continuous rota produced greater continuity but more burnout and no improvements in patient outcomes [Ali 2011].

Survival rates within 30 days of procedure or hospital discharge have improved significantly between 2000-2 and 2009-10 for conditions for which there are well-defined pathways and interventions: non-elective surgery, coronary artery bypass surgery, myocardial infarction and stroke. Admission rates and mortality following myocardial infarction have reduced by 27% and 50% respectively [NHS Information Centre report]. Hip fracture mortality rates are also slowly diminishing [Wu 2011], the slower trend perhaps reflecting a combination of the susceptible population (dependent elderly with complex comorbidities) and the lack of well-defined treatment pathways resulting in unreliable clinical management.

Explicatory mechanisms for these improvements (or possible 'protective' effects for weekday versus weekend admission) are likely to include a combination of better preventative medicine, easier access to and use of technical interventions (e.g.: infection control), and better process control – clearly defined patient pathways, high quality local clinical commitment and leadership, better staffing, and more reliable delivery of care. These mechanisms are more likely to reside in a model of care in which the consultant is present at the bedside.

Specific initiatives to improve outcomes

Of the projects on seven day working reported by NHS Improvement, the great majority are focussed on increasing the amount of time senior experienced staff spend in the clinical environment at weekends and at night, with a smaller number examining new technologies such as electronic prescribing, the electronic patient record, and telemedicine [Steventon 2012], all of which are likely to have an increasingly important role in clinical decision support systems. The Health Foundation's Safer Clinical Systems programme is also currently evaluating quality improvement methodologies in clinical handovers, and in prescribing [Safer Clinical Systems 2012].

In addition to these specific interventions, there are several national initiatives focussed on improving team-working and clinical leadership in caring for the acutely ill patient, and developing standards for consultant involvement in the organisation and delivery of healthcare. Seven day consultant working is being considered by Medical Education England's Shape of Medical Training [MEE 2012a] and by the Centre for Workforce Intelligence's Shape of the Medical Workforce [CfWI 2012], and is also being piloted as part of Better Training, Better Care [MEE 2012b] following on from recommendations for more consultant-delivered care to lead and protect postgraduate education in the Temple Report

[Temple 2012]. The Royal College of Physicians (RCP) evaluation of consultant input into acute medical admissions [Lambourne 2012] found that amongst the 61% of responding Trusts, almost half were unable to dedicate the on-call consultant solely to emergency care. Case mix-adjusted mortality rates were lower in hospitals with consultants dedicated to the on-call work, working in blocks of several days, and offering two formal patient reviews a day. RCP standards recommend that consultant physicians managing acute medical admissions should be present in the acute medical unit (AMU) for more than 4 hours a day, should be available on site for 12 hours a day, seven days a week, free of other competing duties, should review patients in AMUs formally twice a day, and that there should be additional research to determine the relationship between organisational structures and workforce on weekend mortality [RCP Standards document 2011].

These standards have been adopted by London Health care for commissioning [NHS London Health Programme 2011]. The Society of Acute Medicine has defined standards for the staffing and organisation of acute medicine units [WMQRS-SAM 2012; Lees 2012] which emphasise the importance of the supporting infrastructure which surrounds consultant-led care; the Society is developing a standard for 12-hour consultant presence in the AMU. The Faculty of Intensive Care Medicine and the Intensive Care Society are also developing joint national standards which will include recommendations for consultant presence in ICUs. This year has seen the launch by the Royal College of Physicians of the Future Hospital Commission [RCP London 2012] which will produce recommendations for the reconfiguration of hospital services particularly those focussed on acute care. The Academy of Medical Royal Colleges (AoMRC) has published an evidence review showing the benefits of consultant-delivered care, and has called for more robust research in this area [AoMRC 2012].

Summary

The weekend effect is very likely attributable to deficiencies in care processes linked to the absence of skilled and empowered senior staff in a system which is not configured to provide full diagnostic and support services seven days a week. The inexorable increase in emergency admissions creates additional tensions in delivering elective care. Diseases with well-defined diagnostic and treatment pathways are less susceptible to the weekend effect, probably because of better process control. The most effective way to improve outcomes for patients admitted to hospital at weekends is to ensure that care is delivered by adequately supported consultants and monitored using care pathways.

BIBLIOGRAPHY TO APPENDIX B

Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA. 2002 Oct 23-30;288(16):1987-93.

Aylin P, Yunus A, Bottle A, Majeed A, Bell D. Weekend mortality for emergency admissions. A large, multicentre study. Qual Saf Health Care. 2010 Jun;19(3):213-7. Epub 2010 Jan 28.

Blunt I, Bardsley M, Dixon J. Trends in emergency admissions in England 2004 – 2009. Nuffield Trust 2010.http://www.nuffieldtrust.org.uk/publications/trends-emergency-admissions-england-2004-2009?gclid=CIHJxv6U1rECFYQKfAod23UA-w

Buckley D, Bulger D. Trends and weekly and seasonal cycles in the rate of errors in the clinical management of hospitalized patients.Chronobiol Int. 2012 Aug;29(7):947-54. Epub 2012 Jun 4.

Cavallazzi R, Marik PE, Hirani A, Pachinburavan M, Vasu TS, Leiby BE. Association between time of admission to the ICU and mortality: a systematic review and meta analysis. Chest. 2010 Jul;138(1):68-75. Epub 2010 Apr 23.

Cho SH, Hwang JH, Kim J. Nurse staffing and patient mortality in intensive care units. Nurs Res. 2008 Sep-Oct;57(5):322-30.

Cram P, Hillis SL, Barnett M, Rosenthal GE. Effects of weekend admission and hospital teaching status on in-hospital mortality. Am J Med. 2004 Aug 1;117(3):151-7.

De Cordova PB, Phibbs C S, Bartel AP, Stone PW. Twenty-four/seven: a mixed-method systematic review of the off-shift literature. Journal of Advanced Nursing 2012; 68(7): 1454–1468.

Deshmukh A, Pant S, Kumar G, Bursac Z, Paydak H, Mehta JL. Comparison of outcomes of weekend versus weekday admissions for atrial fibrillation. Am J Cardiol. 2012 Jul 15;110(2):208-11. Epub 2012 Apr 3.

Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Shahian D, Roche WR, Stephens I, Keogh B, Pagano D. Weekend hospitalization and additional risk of death: an analysis of inpatient data. J R Soc Med. 2012 Feb;105(2):74-84. Epub 2012 Feb 2.

Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.BMJ Qual Saf. 2012 Jul 7. [Epub ahead of print]

James MT, Wald R, Bell CM, Tonelli M, Hemmelgarn BR, Waikar SS, Chertow GM. Weekend hospital admission, acute kidney injury, and mortality. J Am Soc Nephrol. 2010 May;21(5):845-51. Epub 2010 Apr 15.

Kane RL, Shamliyan TA, Mueller C, Duval S, Wilt TJ. The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. Med Care. 2007 Dec;45(12):1195-204.

Kane RL, Shamliyan T, Mueller C, Duval S, Wilt TJ. Nurse staffing and quality of patient care. Evid Rep Technol Assess (Full Rep). 2007 Mar;(151):1-115.

Kim MM, Barnato AE, Angus DC, Fleisher LA, Kahn JM.The effect of multidisciplinary care teams on intensive care unit mortality. Arch Intern Med. 2010 Feb 22;170(4):369-76.

Kostis WJ, Demissie K, Marcella SW, Shao YH, Wilson AC, Moreyra AE; Myocardial Infarction Data Acquisition System (MIDAS 10) Study Group.Weekend versus weekday admission and mortality from myocardial infarction. N Engl J Med. 2007 Mar 15;356(11):1099-109

Kruse O, Grunnet N, Barfod C.Blood lactate as a predictor for in-hospital mortality in patients admitted acutely to hospital: a systematic review.Scand J Trauma Resusc Emerg Med. 2011 Dec 28;19:74.

Levy MM, Dellinger RP, Townsend SR, Linde-Zwirble WT, Marshall JC, Bion J, Schorr C, Artigas A, Ramsay G, Beale R, Parker MM, Gerlach H, Reinhart K, Silva E, Harvey M, Regan S, Angus DC. The Surviving Sepsis Campaign: results of an international guideline-based performance improvement program targeting severe sepsis. Intensive Care Med. 2010 Feb;36(2):222-31. Epub 2010 Jan 13.

McGaughey J, Alderdice F, Fowler R, Kapila A, Mayhew A, Moutray M.Outreach and Early Warning Systems (EWS) for the prevention of intensive care admission and death of critically ill adult patients on general hospital wards. Cochrane Database Syst Rev. 2007 Jul 18;(3):CD005529.

McKinney JS, Deng Y, Kasner SE, Kostis JB; Myocardial Infarction Data Acquisition System (MIDAS 15) Study Group.Comprehensive stroke centers overcome the weekend versus weekday gap in stroke treatment and mortality.Stroke. 2011 Sep;42(9):2403-9. Epub 2011 Aug 25.

Mohammed MA, Sidhu KS, Rudge G, Stevens AJ. Weekend admission to hospital has a higher risk of death in the elective setting than in the emergency setting: a retrospective database study of national health service hospitals in England. BMC Health Serv Res. 2012 Apr 2;12:87.

Needleman J, Buerhaus P, Mattke S, Stewart M, Zelevinsky K. Nurse-staffing levels and the quality of care in hospitals. N Engl J Med. 2002 May 30;346(22):1715-22.

Penoyer DA.Nurse staffing and patient outcomes in critical care: a concise review. Crit Care Med. 2010 Jul;38(7):1521-8.

Pronovost PJ, Angus DC, Dorman T, Robinson KA, Dremsizov TT, Young TL.Physician staffing patterns and clinical outcomes in critically ill patients: a systematic review. JAMA. 2002 Nov 6;288(17):2151-62.

Smolina K, Wright FL, Rayner M, Goldacre MJ. Determinants of the decline in mortality from acute myocardial infarction in England between 2002 and 2010: linked national database study. BMJ. 2012 Jan 25;344:d8059. doi: 10.1136/bmj.d8059.

Vlayen A, Verelst S, Bekkering GE, Schrooten W, Hellings J, Claes N. Incidence and preventability of adverse events requiring intensive care admission: a systematic review.J Eval Clin Pract. 2012 Apr;18(2):485-97. doi: 10.1111/j.1365-2753.2010.01612.x. Epub 2011 Jan 6.

Wallace DJ, Angus DC, Barnato AE, Kramer AA, Kahn JM.Nighttime intensivist staffing and mortality among critically ill patients. N Engl J Med. 2012 May 31;366(22):2093-101. Epub 2012 May 21.

Worni M, Schudel IM, Ostbye T, Shah A, Khare A, Pietrobon R, Thacker JK, Guller U. Worse Outcomes in Patients Undergoing Urgent Surgery for Left-Sided Diverticulitis Admitted on Weekends vs Weekdays: A Population-Based Study of 31 832 Patients. Arch Surg. 2012 Jul 1;147(7):649-55.

Wu TY, Jen MH, Bottle A, Liaw CK, Aylin P, Majeed A.Admission rates and in-hospital mortality for hip fractures in England 1998 to 2009: time trends study. J Public Health (Oxf). 2011 Jun;33(2):284-91. Epub 2010 Oct 5.

NHS Information Centre report: http://www.ic.nhs.uk/pubs/hesdeaths0910

Royal College of Physicians of London (1). National early warning score (NEWS): standardising the assessment of acute-illness severity in the NHS—report of a working party. 2012. www.rcplondon.ac.uk/resources/national-early-warning-score-news.

Royal College of Physicians of London 2012 (2). (http://www.rcplondon.ac.uk/press-releases/quarter-physicians-say-continuity-care-poor-their-hospital) Feb 2012.

Royal College of Physicians of London 2012 (3). http://www.rcplondon.ac.uk/projects/future-hospital-commission

AoMRC 2012 (1).http://aomrc.org.uk/projects/seven-day-working.html

AoMRC 2012 (2). Benefits of Consultant Delivered Care. Academy of Medical Royal Colleges, January 12th 2012.http://www.aomrc.org.uk/about-us/news/item/benefits-of-consultant-delivered-care.html

Safer Clinical Systems. The Health Foundation 2012.http://www.health.org.uk/areas-of-work/programmes/safer-clinical-systems/

Acutely ill patients in hospital. NICE Guideline 50, NICE 2007.http://www.nice.org.uk/nicemedia/live/11810/35950/35950.pdf

Acutely ill patients in Hospital, NICE Pathway. http://pathways.nice.org.uk/pathways/acutely-ill-patients-in-hospital

Medical Education England (MEE 2012a).http://www.mee.nhs.uk/our_work/work_priorities/shape_of_medical_training.aspx

Centre for Workforce Intelligence (CfWi 2012). http://www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce

Medical Education England (MEE 2012b). Better Training, Better Care. http://www.mee.nhs.uk/our_work/work_priorities/better_training_better_care.aspx

Temple J. Time for Training: a review of the impact of the European Working Time Directive on the quality of training. Secretary of State for Health. May 2010.http://www.mee.nhs.uk/PDF/JCEWTD_Final%20report.pdf

NHS London Health Programme. Review of acute medicine and emergency general surgery services. September 21, 2011.http://www.londonhp.nhs.uk/publications/adult-emergency-services

Lambourne A, Percival F, Ward D, Laverty AA, Bell D.An evaluation of consultant input into acute medical admissions management in England. Report of hospital service patterns versus clinical outcomes in England. Royal College of Physicians 2012.http://www.rcplondon.ac.uk/sites/default/files/an-evaluation-of-consultant-input-into-acute-medical-admissions-management-in-england-2012.pdf

RCP Standards document 2011. Acute Care Toolkit 2. High Quality Acute Care. Royal College of Physicians October 2011.http://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf

NHS London Health Programme. Adult emergency services: Acute medicine and emergency general surgery. Commissioning standards. September 21, 2011.

WMQRS-SAM. Quality Standards for Acute Medical Units. Society for Acute Medicine 2012. http://www.acutemedicine.org.uk/images/stories/pdf/wmqrs-sam%20am%20qss%20v2%2020120610%201.pdf

Lees L. The Coordinator Role in Acute Medicine. Principles for effective coordination of an acute medicine unit. Society for Acute Medicine June 2012. http://www.acutemedicine.org.uk/images/stories/pdf/the%20coordinator%20role%20in%20am.pdf

Provisional Monthly HES data for Admitted Patient Care. http://www.hesonline.nhs.uk/Ease/ContentServer?siteID=1937&categoryID=1122

Hospital at Night: http://www.healthcareworkforce.nhs.uk/hospitalatnight.html

Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, January 2011 - December 2011, Experimental Statistics. NHS Information Centre Hospital Episode Statistics.https://indicators.ic.nhs.uk/download/SHMI/July_2012/Specification/EXECUTIVE_SUMMARY.pdf

Black N, Jenkinson C. Measuring patients' experiences and outcomes.BMJ. 2009 Jul 2;339:b2495. doi: 10.1136/bmj.b2495

Rademakers J, Delnoij D, de Boer D.Structure, process or outcome: which contributes most to patients' overall assessment of healthcare quality? BMJ Quality & Safety 2011; 20(4): 326-331DOI: 10.1136/bmjqs.2010.042358.

Greenhalgh J, Long AF, Flynn R. The use of patient reported outcome measures in routine clinical practice: lack of impact or lack of theory? Soc Sci Med. 2005 Feb;60(4):833-43.

NIAA-HSRC: National Institute for Academic Anaesthesia (NIAA) Health Services Research Centre (HSRC) http://www.niaa-hsrc.org.uk/HSRC_home

Saunders DI, Murray D, Pichel AC, Varley S, Peden CJ on behalf of the members of the UK Emergency Laparotomy Network. Variations in mortality after emergency laparotomy: the first report of the UK Emergency Laparotomy Network. British Journal of Anaesthesia 2012; doi: 10.1093/bja/aes165

White SM, Griffiths R.Projected incidence of proximal femoral fracture in England: a report from the NHS Hip Fracture Anaesthesia Network (HIPFAN). Injury. 2011 Nov;42(11):1230-3. Epub 2010 Dec 22.

Aveling EL, Martin G, Jiménez García S, Martin L, Herbert G, Armstrong N, Dixon-Woods M, Woolhouse I. Reciprocal peer review for quality improvement: an ethnographic case study of the Improving Lung Cancer Outcomes Project.BMJ Qual Saf. 2012 Aug 9. [Epub ahead of print]

Hemming K, Girling AJ, Sitch AJ, Marsh J, Lilford RJ. Sample size calculations for cluster randomised controlled trials with a fixed number of clusters. BMC Med Res Methodol. 2011 Jun 30;11:102.

Royal College of Physicians (London). An Evaluation of Consultant Input into Acute Medical Admissions Management in England, Wales and Northern Ireland. Report of a descriptive survey and audit results against national guidelines October 2010. Available at: http://www.rcplondon.ac.uk/sites/default/files/consultant-input-into-acute-medical-admissions-management-oct-2010.pdf

Association of weekend admission with higher mortality

Aylin P, Yunus A, Bottle A, Majeed A, Bell D. Weekend mortality for emergency admissions. A large, multicentre study.Qual Saf Health Care. 2010 Jun;19(3):213-7. Epub 2010 Jan 28.

Bell CM, Redelmeier DA. Mortality among patients admitted to hospitals on weekends as compared with weekdays. N Engl J Med 2001;345:663-8.

Buckley D, Bulger D. Trends and weekly and seasonal cycles in the rate of errors in the clinical management of hospitalized patients. Chronobiol Int. 2012 Aug;29(7):947-54. Epub 2012 Jun 4.

Cavallazzi R, Marik PE, Hirani A, Pachinburavan M, Vasu TS, Leiby BE. Association between time of admission to the ICU and mortality: a systematic review and meta analysis. Chest. 2010 Jul;138(1):68-75. Epub 2010 Apr 23.

Cram P, Hillis SL, Barnett M, Rosenthal GE.Effects of weekend admission and hospital teaching status on in-hospital mortality. Am J Med. 2004 Aug 1;117(3):151-7.

De Cordova PB, Phibbs C S, Bartel AP, Stone PW. Twenty-four/seven: a mixed-method systematic review of the off-shift literature. Journal of Advanced Nursing 2012; 68(7): 1454–1468.

Deshmukh A, Pant S, Kumar G, Bursac Z, Paydak H, Mehta JL. Comparison of outcomes of weekend versus weekday admissions for atrial fibrillation. Am J Cardiol. 2012 Jul 15;110(2):208-11. Epub 2012 Apr 3.

Freemantle N, Richardson M, Wood J, Ray D, Khosla S, Shahian D, Roche WR, Stephens I, Keogh B, Pagano D. Weekend hospitalization and additional risk of death: an analysis of inpatient data. J R Soc Med. 2012 Feb;105(2):74-84. Epub 2012 Feb 2.

[Freemantle 2012, Mohammed 2012, Cram 2004, Cavallazzi 2010, Aylin 2010, Kruse 2011, Buckley 2012, MaGaughey 2007, James 2010, Worni 2012, De Cordova 2012, Deshmukh 2012]

James MT, Wald R, Bell CM, Tonelli M, Hemmelgarn BR, Waikar SS, Chertow GM. Weekend hospital admission, acute kidney injury, and mortality.J Am Soc Nephrol. 2010 May;21(5):845-51. Epub 2010 Apr 15.

Kruse O, Grunnet N, Barfod C.Blood lactate as a predictor for in-hospital mortality in patients admitted acutely to hospital: a systematic review. Scand J Trauma Resusc Emerg Med. 2011 Dec 28;19:74.

McGaughey J, Alderdice F, Fowler R, Kapila A, Mayhew A, Moutray M.Outreach and Early Warning Systems (EWS) for the prevention of intensive care admission and death of critically ill adult patients on general hospital wards. Cochrane Database Syst Rev. 2007 Jul 18;(3):CD005529.

Mohammed MA, Sidhu KS, Rudge G, Stevens AJ. Weekend admission to hospital has a higher risk of death in the elective setting than in the emergency setting: a retrospective database study of national health service hospitals in England. BMC Health Serv Res. 2012 Apr 2;12:87.

Worni M, Schudel IM, Ostbye T, Shah A, Khare A, Pietrobon R, Thacker JK, Guller U. Worse Outcomes in Patients Undergoing Urgent Surgery for Left-Sided Diverticulitis Admitted on Weekends vs Weekdays: A Population-Based Study of 31 832 Patients. Arch Surg. 2012 Jul 1;147(7):649-55.

No impact of weekend admission on outcome

Byun SJ, Kim SU, Park JY, Kim BK, Kim do Y, Han KH, Chon CY, Ahn SH. Acute variceal hemorrhage in patients with liver cirrhosis: weekend versus weekday admissions. Yonsei Med J. 2012 Mar;53(2):318-27. doi: 10.3349/ymj.2012.53.2.318.

Kazley AS, Hillman DG, Johnston KC, Simpson KN. Hospital care for patients experiencing weekend vs weekday stroke: a comparison of quality and aggressiveness of care. Arch Neurol. 2010 Jan;67(1):39-44.

Kevin B. Laupland. (2010) Admission to hospital with community-onset bloodstream infection during the 'after hours' is not associated with an increased risk for death. Scandinavian Journal of Infectious Diseases 42:11-12, 862-865

Myers RP, Kaplan GG, Shaheen AM.The effect of weekend versus weekday admission on outcomes of esophageal variceal hemorrhage.Can J Gastroenterol. 2009 Jul;23(7):495-501.
Orman ES, Hayashi PH, Dellon ES, Gerber DA, Barritt AS 4th.Impact of nighttime and weekend liver transplants on graft and patient outcomes. Liver Transpl. 2012 May;18(5):558-65. doi: 10.1002/lt.23395

Worni M, Østbye T, Gandhi M, Rajgor D, Shah J, Shah A, Pietrobon R, Jacobs DO, Guller U.Laparoscopic appendectomy outcomes on the weekend and during the week are no different: a national study of 151,774 patients. World J Surg. 2012 Jul;36(7):1527-33.

Staffing

Aiken LH, Clarke SP, Sloane DM, Sochalski J, Silber JH.Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. JAMA. 2002 Oct 23-30;288(16):1987-93.
Cho SH, Hwang JH, Kim J.Nurse staffing and patient mortality in intensive care units. Nurs Res. 2008 Sep-Oct;57(5):322-30.

Kane RL, Shamliyan TA, Mueller C, Duval S, Wilt TJ.The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis. Med Care. 2007 Dec;45(12):1195-204.

Kane RL, Shamliyan T, Mueller C, Duval S, Wilt TJ. Nurse staffing and quality of patient care. Evid Rep Technol Assess (Full Rep). 2007 Mar;(151):1-115.

[Kane 2007, Cho 2008, Kane 2007, Needleman 2002, Pronovost 2002, Wallace 2012, Kim 2010, Aiken 2002, Penoyer 2010]

Kim MM, Barnato AE, Angus DC, Fleisher LA, Kahn JM.The effect of multidisciplinary care teams on intensive care unit mortality. Arch Intern Med. 2010 Feb 22;170(4):369-76.

Needleman J, Buerhaus P, Mattke S, Stewart M, Zelevinsky K. Nurse-staffing levels and the quality of care in hospitals. N Engl J Med. 2002 May 30;346(22):1715-22.

Penoyer DA. Nurse staffing and patient outcomes in critical care: a concise review. Crit Care Med. 2010 Jul;38(7):1521-8.
Pronovost PJ, Angus DC, Dorman T, Robinson KA, Dremsizov TT, Young TL. Physician staffing patterns and clinical outcomes in critically ill patients: a systematic review. JAMA. 2002 Nov 6;288(17):2151-62.

Wallace DJ, Angus DC, Barnato AE, Kramer AA, Kahn JM. Nighttime intensivist staffing and mortality among critically ill patients .N Engl J Med. 2012 May 31;366(22):2093-101. Epub 2012 May 21.

Garland A, Roberts D, Graff L. Twenty-four-hour intensivist presence: a pilot study of effects on intensive care unit patients, families, doctors, and nurses.Am J Respir Crit Care Med. 2012 Apr 1;185(7):738-43. Epub 2012 Jan 12.

Ali NA, Hammersley J, Hoffmann SP, O'Brien JM Jr, Phillips GS, Rashkin M, Warren E, Garland A; Midwest Critical Care Consortium. Continuity of care in intensive care units: a cluster-randomized trial of intensivist staffing. Am J Respir Crit Care Med. 2011 Oct 1;184(7):803-8.

Improving outcomes, potential interventions

Kostis WJ, Demissie K, Marcella SW, Shao YH, Wilson AC, Moreyra AE; Myocardial Infarction Data Acquisition System (MIDAS 10) Study Group. Weekend versus weekday admission and mortality from myocardial infarction. N Engl J Med. 2007 Mar 15;356(11):1099-109.

J. Krueger, Edward C. Halperin. (2010) Perspective: Paying Physicians to Be On Call: A Challenge for Academic Medicine. Academic Medicine 85:12, 1840-1844

Levy MM, Dellinger RP, Townsend SR, Linde-Zwirble WT, Marshall JC, Bion J, Schorr C, Artigas A, Ramsay G, Beale R, Parker MM, Gerlach H, Reinhart K, Silva E, Harvey M, Regan S, Angus DC. The Surviving Sepsis Campaign: results of an international guideline-based performance improvement program targeting severe sepsis. Intensive Care Med. 2010 Feb;36(2):222-31. Epub 2010 Jan 13.

McKinney JS, Deng Y, Kasner SE, Kostis JB; Myocardial Infarction Data Acquisition System (MIDAS 15) Study Group. Comprehensive stroke centers overcome the weekend versus weekday gap in stroke treatment and mortality. Stroke. 2011 Sep;42(9):2403-9. Epub 2011 Aug 25.

Scott P, Ross P, Prytherch D. Evidence-based inpatient handovers: a literature review and research agenda. Clinical Governance: An International Journal 2012; Vol. 17 Iss: 1, 14 – 27.DOI :10.1108/14777271211200710

Selby NM, Crowley L, Fluck RJ, McIntyre CW, Monaghan J, Lawson N, Kolhe NV.Use of electronic results reporting to diagnose and monitor AKI in hospitalized patients.Clin J Am Soc Nephrol. 2012 Apr;7(4):533-40. Epub 2012 Feb 23.

Smolina K, Wright FL, Rayner M, Goldacre MJ. Determinants of the decline in mortality from acute myocardial infarction in England between 2002 and 2010: linked national database study. BMJ. 2012 Jan 25;344:d8059. doi: 10.1136/bmj.d8059.

Wu TY, Jen MH, Bottle A, Liaw CK, Aylin P, Majeed A. Admission rates and in-hospital mortality for hip fractures in England 1998 to 2009: time trends study.J Public Health (Oxf). 2011 Jun;33(2):284-91. Epub 2010 Oct 5.

Causation or preventability

Anderson CI, Nelson CS, Graham CF, Mosher BD, Gohil KN, Morrison CA, Schneider PD, Kepros JP. Disorganized care: The findings of an iterative, in-depth analysis of surgical morbidity and mortality. J Surg Res. 2012 Jun 5 [e-pub].

Hogan H, Healey F, Neale G, Thomson R, Vincent C, Black N. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study.BMJ Qual Saf. 2012 Jul 7. [Epub ahead of print]

Mitchell EL, Lee DY, Arora S, Kwong KL, Liem TK, Landry GL, Moneta GL, Sevdalis N.SBAR M&M: a feasible, reliable, and valid tool to assess the quality of, surgical morbidity and mortality conference presentations. Am J Surg. 2012 Jan;203(1):26-31. Epub 2011 Nov 16.

Vlayen A, Verelst S, Bekkering GE, Schrooten W, Hellings J, Claes N.Incidence and preventability of adverse events requiring intensive care admission: a systematic review.J Eval Clin Pract. 2012 Apr;18(2):485-97. doi: 10.1111/j.1365-2753.2010.01612.x. Epub 2011 Jan 6.

Tam V, Frost SA, Hillman KM, Salamonson Y. Using administrative data to develop a nomogram for individualising risk of unplanned admission to intensive care. Resuscitation 2008; 79:2, 241-248

Benning A, Dixon-Woods M, Nwulu U, Ghaleb M, Dawson J, Barber N, Franklin BD, Girling A, Hemming K, Carmalt M, Rudge G, Naicker T, Kotecha A, Derrington MC, Lilford R. Multiple component patient safety intervention in English hospitals: controlled evaluation of second phase. BMJ. 2011 Feb 3;342:d199. doi: 10.1136/bmj.d199.

Benning A, Ghaleb M, Suokas A, Dixon-Woods M, Dawson J, Barber N, Franklin BD, Girling A, Hemming K, Carmalt M, Rudge G, Naicker T, Nwulu U, Choudhury S, Lilford R. Large scale organisational intervention to improve patient safety in four UK hospitals: mixed method evaluation. BMJ. 2011 Feb 3;342:d195. doi: 10.1136/bmj.d195.

The Matching Michigan Collaboration. 'Matching Michigan': a two-year stepped interventional programme to minimise central venous catheter-blood stream infections in intensive care units in England. BMJ Quality & Safety 2012; in press.

McGlynn EA, Asch SM, Adams J, Keesey J, Hicks J, DeCristofaro A, Kerr EA. The quality of health care delivered to adults in the United States.N Engl J Med. 2003 Jun 26;348(26):2635-45.

Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, Day RO, Hindmarsh DM, McGlynn EA, Braithwaite J. Care Track: assessing the appropriateness of health care delivery in Australia. Med J Aust. 2012 Jul 16;197(2):100-5.

Braithwaite RS, DeVita MA, Mahidhara R, Simmons RL, Stuart S, Foraida M; Medical Emergency Response Improvement Team (MERIT).Use of medical emergency team (MET) responses to detect medical errors. Qual Saf Health Care. 2004 Aug;13(4):255-9.

McQuillan P, Pilkington S, Allan A, Taylor B, Short A, Morgan G, Nielsen M, Barrett D, Smith G, Collins CH. Confidential inquiry into quality of care before admission to intensive care.BMJ. 1998 Jun 20;316(7148):1853-8.

Hayward RA, Hofer TP. Estimating hospital deaths due to medical errors: preventability is in the eye of the reviewer. JAMA. 2001 Jul 25;286(4):415-20.

Vlayen A, Verelst S, Bekkering GE, Schrooten W, Hellings J, Claes N.Incidence and preventability of adverse events requiring intensive care admission: a systematic review. J Eval Clin Pract. 2012 Apr;18(2):485-97. doi: 10.1111/j.1365-2753.2010.01612.x. Epub 2011 Jan 6.

Steventon A, Bardsley M, Billings J, Dixon J, Doll H, Hirani S, Cartwright M, Rixon L, Knapp M, Henderson C, Rogers A, Fitzpatrick R, Hendy J, Newman S; Whole System Demonstrator Evaluation Team. Effect of telehealth on use of secondary care and mortality: findings from the Whole System Demonstrator cluster randomised trial.BMJ. 2012 Jun 21;344:e3874. doi: 10.1136/bmj.e3874.

Brown C, Hofer T, Johal A, Thomson R, Nicholl J, Franklin BD, Lilford RJ. An epistemology of patient safety research: a framework for study design and interpretation. Part 4. One size does not fit all. Qual Saf Health Care. 2008 Jun;17(3):178-81.

Brown C, Hofer T, Johal A, Thomson R, Nicholl J, Franklin BD, Lilford RJ.An epistemology of patient safety research: a framework for study design and interpretation. Part 3. End points and measurement. Qual Saf Health Care. 2008 Jun;17(3):170-7.

Brown C, Hofer T, Johal A, Thomson R, Nicholl J, Franklin BD, Lilford RJ.An epistemology of patient safety research: a framework for study design and interpretation. Part 2. Study design. Qual Saf Health Care. 2008 Jun;17(3):163-9.

Brown C, Hofer T, Johal A, Thomson R, Nicholl J, Franklin BD, Lilford RJ. An epistemology of patient safety research: a framework for study design and interpretation. Part 1. Conceptualising and developing interventions. Qual Saf Health Care. 2008 Jun;17(3):158-62.

Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away.BMJ. 2010 Apr 20;340:c2016. doi: 10.1136/bmj.c2016.

Sharma U, Reed J, Doyle C, Bell D. Challenges in evaluating telehealth through RCT-the problem of randomization. Stud Health Technol Inform. 2012;180:323-7

Case for Hospital at Night - The Search for Evidence (2010). http://www.healthcareworkforce.nhs.uk/hospitalatnight.html

McGaughey J, Alderdice F, Fowler R, Kapila A, Mayhew A, Moutray M. Outreach and Early Warning Systems (EWS) for the prevention of intensive care admission and death of critically ill adult patients on general hospital wards. Cochrane Database Syst Rev. 2007 Jul 18;(3):CD005529.

APPENDIX C
PUBLISHED STATEMENTS ON SEVEN DAY CONSULTANT PRESENCE

Medical Royal College, Organisation or Specialty	Statement	Document / Date
Anaesthetists		Guidelines for the provision of Anaesthetic Services, 2009
Association of Surgeons of Great Britain and Ireland	The provision of protected and separately staffed, consultant-based theatre access from 15.00 to 22.00 would make a considerable impact on delays and outcomes.	Emergency General Surgery, 2012
Emergency Medicine	Every Emergency Department should have at least 10 EM consultants to provide up to 16 hours of direct patient care seven days a week.	Emergency Medicine Operational Handbook – The Way Ahead, December 2011
Geriatric Medicine		NCEPOD – An age old problem, 2010
	Discharge to an older persons normal residence should be possible within 24 hours, seven days a week.	The Silver Book, 2012
Haematology	Haematologists offer a broad, uninterrupted clinical and advisory service for all sub-specialty problems 24 hours a day.	Haematology Consultant Workforce – the next ten years, 2008
Intensive Care Medicine	Patient Care Directed By A Consultant Intensivist Consultant Intensivist Patient Review Within 12 Hours Of Emergency Admission to ICU Routine Multi-Disciplinary Ward Round every day of the year Standardised Handover Procedure For Discharging Patients	Submission to National Institute for Clinical Excellence October 2011
Obstetricians and Gynaecologists	Hours of consultant presence defined by unit size – incorporated into NHS LAs in 2012	Safer Childbirth 2007

Medical Royal College, Organisation or Specialty	Statement	Document / Date
Paediatrics and Child Health		Consultant Delivered Care – An evaluation of new ways of working in paediatrics, April 2012
Pathologists		Medical & Scientific Staffing of NHS Pathology Departments, 1999
Physicians, London	Any hospital admitting acutely ill patients should have a consultant physician on site for at least 12 hours per day seven days per week, with no other duties scheduled during that time	College Council Position Statement, November 2010
Psychiatrists		Safe patients – High quality Services: A guide to job descriptions and job plans for Consultant Psychiatrists, May 2012
Radiologists		Investing in the Clinical Radiology Workforce – the Quality and Efficiency Case, June 2012 Guide to Job Planning in Clinical Oncology – second edition
Society of Acute Medicine		Acute Medicine Toolkit, 2012
Stroke medicine	All suspected stroke patients to have 24/7 access to immediate assessment and thrombolysis where appropriate.	National Stroke Strategy, 2007
Surgeons, England	Recommendations include: Adequate emergency theatre time throughout the day Timely input of senior decision makers A consultant-led service across all specialties	The Higher Risk General Surgery Patient, 2011 Emergency Surgery – Standards for unscheduled surgical care, 2011

REFERENCES

1. Academy of Medical Royal Colleges. (2012) The Benefits of consultant-delivered care. Academy of Medical Royal Colleges.

2. Temple, J. (2010) Time for Training – A review of the impact of the European Working Time Directive on the quality of training. Medical Education England
Available at: http://www.mee.nhs.uk/PDF/14274%20Bookmark%20Web%20Version.pdf

3. Dr Foster Hospital Guide. (2011) Inside your Hospital. Dr Foster Intelligence.

4. NHS London (2011) Adult emergency services: Acute medicine and emergencygeneral surgery - Case for change.
Available at: http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

5. The Royal College of Surgeons. (2011) Emergency Surgery: Standards for unscheduled care produced standards for unscheduled surgical care. RCSENG - Professional Standards and Regulation.

6. NHS Improvement. (2012) Equality for all: Delivering safe care – seven days a week.
Available at: http://www.improvement.nhs.uk/documents/SevenDayWorking.pdf

7. National Institute for health and Clinical Excellence. NICE Quality standards.
Available at: http://www.nice.org.uk/guidance/qualitystandards.jsp

8. The Royal College of Paediatrics and Child Health. (2012) Consultant Delivered Care – an evaluation of new ways of working in paediatrics.
Available at: http://www.rcpch.ac.uk/system/files/protected/page/CDC%20full%20report%2024%2004%2012%20V2.pdf

9. The Royal College of Obstetricians and Gynaecologists. (2012) Tomorrow's Specialist.
Available at: http://www.rcog.org.uk/files/rcog-corp/Tomorrow's%20Specialist_FullReport.pdf

10. Royal College of Physicians of London. (2012) Acute care toolkit 4: delivering a 12-hour, 7-day consultant presence on the acute medical unit.
Available at: http://www.rcplondon.ac.uk/sites/default/files/documents/acute-care-toolkit-4.pdf

11. Royal College of Physicians, Royal College of Nursing. (2012) Ward rounds in medicine: principles for best practice. London: RCP, 2012.
Available at: http://www.rcplondon.ac.uk/sites/default/files/documents/ward-rounds-in-medicine-web.pdf

12. Royal College of Physicians of London (2012) The Future Hospital Commission.
Project information available at: http://www.rcplondon.ac.uk/projects/future-hospital-commission

13. The National Institute of Health Research. (2012) Commissioning Brief (12/128) The organisation and delivery of 24/7 healthcare. Health Services and Delivery Research Programme
Available at: http://www.health.org.uk/areas-of-work/programmes/flow-cost-quality

14. The Health Foundation. (2012) Flow Cost Quality Programme.
Project information available at:
http://www.health.org.uk/areas-of-work/programmes/flow-cost-quality

15. Royal College of Physicians. (2011) Acute care toolkit 2: high-quality acute care.
Available at: http://www.rcplondon.ac.uk/sites/default/files/acute-care-toolkit-2-high-quality-acute-care.pdf

16. The Royal College of Physicians. (2012) An evaluation of consultant input into acute medical admissions management in England.
Available at: http://www.rcplondon.ac.uk/sites/default/files/an-evaluation-of-consultant-input-into-acute-medical-admissions-management-in-england-2012.pdf

17. The Centre for Workforce Intelligence. (2012) Shape of the medical workforce: Starting the debate on the future consultant workforce.
Available at: http://www.cfwi.org.uk/publications/leaders-report-shape-of-the-medical-workforce

18. NHS Confederation, AoMRC, BMA, JMCC. (2010) Clinical Responses to the Downturn. NHS Confederation.

Academy of Medical Royal Colleges
10 Dallington Street
London
EC1V 0DB

Registered Charity
Number 1056565

Imperial College Healthcare NHS Trust submission to Commission of Inquiry into the Reconfiguration of Acute Care Services in North West London

1. Purpose

1.1 Imperial College Healthcare NHS Trust ('the Trust') welcomes the opportunity to provide this submission to the Commission of Inquiry into the Reconfiguration of Acute Care Services in North West London.

1.2 According to its terms of reference, the Commission will, amongst other areas of its work:

> "Review and report on the likely impact of the Imperial College Healthcare NHS Trust's Clinical Strategy 2014-20, and any equivalent plans from London North West Healthcare NHS Trust or its predecessors, on the residents of North West London."

1.3 A press release from the London Borough of Hammersmith & Fulham dated 15 January 2015, also stated:

> "The changes under scrutiny include the closures of A&Es at Hammersmith and Central Middlesex hospitals last September and the planned loss of acute care beds. The independent commission will also review plans to:
> 1. Demolish the current Charing Cross Hospital and replace it with a smaller building, a fraction of the size of the former hospital, and with a series of significantly scaled down health services.
> 2. Scale down Charing Cross Hospital's current A&E to an urgent care clinic (also now defined by the government as a 'Type 3 A&E') that will not take emergency 'blue light' ambulance cases and will mostly be a facility that is led by GPs."

1.4 This submission therefore covers the following areas:

- About the Trust
- Trust vision and objectives
- Trust clinical strategy
- Outline business case for estates development
- Engagement plans
- Integrating community services
- Changes to urgent and emergency services
- Winter resilience planning
- A&E performance and additional actions
- Summary

2. About the Trust

2.1 The Trust comprises Charing Cross, Hammersmith, Queen Charlotte's & Chelsea, St Mary's and the Western Eye hospitals, and was formed in 2007. It is one of the largest acute trusts in the country and, in partnership with Imperial College London, the UK's first academic health science centre (AHSC).

2.2 The Trust delivers world-leading acute and integrated care services, treating patients at every stage of their lives – with over 55 specialist services for both children and adults. In 2013/14, there were:

- 1,223,380 patient contacts
- 192,168 inpatient cases
- 1,031,212 outpatient contacts
- 281,990 accident and emergency (A&E) attendances.

2.3 The Trust is commissioned to provide a broad range of services by the eight clinical commissioning groups (CCGs) serving a population of nearly two million people in North West London. Very specialist services are commissioned by NHS England and a further 80-plus commissioners from across London and around the country.

2.4 Academic health science centre (AHSC)

2.4.1 Together with Imperial College London, the Trust formed the UK's first AHSC in 2009. Imperial College London has a campus on each main Trust site and is closely integrated with all clinical specialties.

2.4.2 Imperial College Healthcare is one of 11 National Institute for Health Research (NIHR) Biomedical Research Centres. This designation is given to the most outstanding NHS and university research partnerships in the country; leaders in scientific translation and early adopters of new insights in technologies, techniques and treatments for improving health.

2.4.3 The Clinical Sciences Centre of the Medical Research Council (MRC) is based at Hammersmith Hospital, providing a strong foundation for clinical and scientific research.

2.5 Five hospitals in the Trust

2.5.1 Charing Cross Hospital, Hammersmith
Charing Cross is a general hospital providing a range of adult clinical services. It hosts one of eight hyper acute stroke units in London and is a site for teaching medical students from Imperial College London.

2.5.2 Hammersmith Hospital, Acton
Hammersmith is a general hospital and home to the heart attack centre for North West London. It is well known for its research achievements; hosting a large community of Imperial College London postgraduate medical students and researchers.

2.5.3 Queen Charlotte's & Chelsea Hospital, Acton
Queen Charlotte's & Chelsea Hospital provides maternity and women's and children's services. The hospital has extensive high-risk services and cares for women with complicated pregnancies. It also has a midwife-led birth centre for women with routine pregnancies who want a natural childbirth experience.

2.5.4 St Mary's Hospital, Paddington
St Mary's Hospital is a general acute hospital that diagnoses and treats a range of adult and child conditions. The hospital also provides maternity services and hosts one of the four major trauma centres in London.

2.5.5 Western Eye Hospital, Marylebone
Western Eye Hospital is dedicated to ophthalmology. It offers the only 24-hour emergency eye care service in west London.

3. Trust vision and objectives

3.1 The Trust has been developing plans for the future of its healthcare services in order to respond to future needs.

3.2 As part of this work, we sharpened and simplified the Trust's vision and strategic objectives. The intention was to develop more accessible and impactful versions to demonstrate more clearly the strategic context for our developments. The refined vision and objectives also helped address one aspect of feedback from our foundation trust application consultation which indicated that many found some of our previously worded objectives difficult to understand.

3.3 Our Trust's vision and strategic objectives are set out below:

Vision:
- To be a world leader in transforming health through innovation in patient care, education and research.

Objectives:
- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion.
- To educate and engage skilled and diverse people committed to continual learning and improvement.
- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care.
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

4. Trust clinical strategy

4.1 At its 30 July 2014 public meeting, the Trust's board of directors approved the document "Clinical Strategy 2014-2020: unlocking our potential to transform health and care" setting out our clinical strategy which is the central element of our five-year clinical and site transformation programme. The strategy is designed to improve

clinical outcomes and patient experience, to help people stay as healthy as possible and to increase access to the most effective specialist care.

4.2 This clinical strategy reflects the well-evidenced principles of what good future NHS care will look like. This means more local and integrated services, to improve access and help keep people healthy, and more concentrated specialist services where necessary, to increase quality and safety. We've already seen many more lives saved by centralising major trauma, stroke and heart attack centres across the capital, including at our hospitals.

4.3 We were encouraged that the Trust's clinical strategy was in correlation with the subsequent 'Five Year Forward View' published by NHS England in October 2014, which stated:

> "...there is broad consensus on what that future needs to be. It is a future that empowers patients to take much more control over their own care and treatment. It is a future that dissolves the classic divide, set almost in stone since 1948, between family doctors and hospitals, between physical and mental health, between health and social care, between prevention and treatment. One that no longer sees expertise locked into often out-dated buildings, with services fragmented, patients having to visit multiple professionals for multiple appointments, endlessly repeating their details because they use separate paper records. One organised to support people with multiple health conditions, not just single diseases. A future that sees far more care delivered locally but with some services in specialist centres where that clearly produces better results. One that recognises that we cannot deliver the necessary change without investing in our current and future workforce."

4.4 While maintaining the Trust's political neutrality and impartiality, we have also noted the consensus amongst the main political parties about the need to change the model for healthcare.

4.4.1 In December 2014, Secretary of State for Health, Rt Hon Jeremy Hunt MP, told Parliament about changing:

> "the models of care to be more suited for an ageing population, where growing numbers of vulnerable older people need support to live better at home with long term conditions like dementia, diabetes and arthritis. To do this we need to focus on prevention as much as cure: helping people stay healthy without allowing illnesses to deteriorate to the point they need expensive hospital treatment."

4.4.2 The publication of 'Labour's 10-Year Plan for Health and Care' followed in January 2015, which stated:

> "The health challenges of the 21st century are very different from those of 1948. After the Second World War, the main challenge was fighting infectious diseases like tuberculosis and diphtheria. Today, long-term conditions like cancer, heart disease and dementia account for 70 per cent of all NHS spending. And large numbers of people, especially older people, have multiple needs.
>
> Yet our health and care services haven't changed to reflect this new reality. They respond to each of our needs separately, focussing on the body part or

the individual problem – the broken leg, the high blood pressure – rather than the person behind it.

This means care is fragmented. It means problems get missed. It means different parts of the system aren't joined up. It means people and their families having to struggle against the system, repeating the same story over and over again to different professionals, and continually passed around between different organisations.

It means opportunities for prevention and for helping people stay healthy and independent outside hospital are often missed."

4.5 The Trust's clinical strategy informed an outline business case (OBC) for a major investment in the redevelopment of our estate. The Trust board also agreed that the OBC should go forward to commissioners and the NHS Trust Development Authority (TDA) for approval to secure funding. This would enable some £660 million of investment in our sites and a three-year construction programme is planned to begin towards the end of 2016/17.

4.6 Set out below are some of the strategy highlights:

- Charing Cross Hospital: a pioneering local hospital
  - £150 million redevelopment
  - Wide range of specialist, planned care (day case surgery/treatment, one-stop diagnostics clinics, outpatients, day chemotherapy, renal dialysis)
  - Integrated care/rehabilitation services, especially for elderly people and those with chronic conditions
  - Emergency centre
  - Co-located with existing partner services, including mental health and cancer support
- St Mary's Hospital: the major acute centre for the region
  - £500 million redevelopment
  - Consolidate Hyper Acute Stroke Unit, A&E, major trauma and intensive care with acute medical and surgical specialities
  - Co-locate services from Western Eye Hospital
- Hammersmith Hospital: a world-leading specialist centre
  - £10 million development
  - Main hub for range of specialties, including renal, haematology, cancer and cardiology, with strong research connections
  - Maintain heart attack specialist centre
  - Maintain co-located Queen Charlotte's and Chelsea Hospital

4.7 We have developed these plans because we have to change to meet the changing needs of our patients. People are living longer, and more and more people are living with long-term conditions like diabetes, heart disease, asthma and dementia. So we need to look forward to what people will need from us in the years to come.

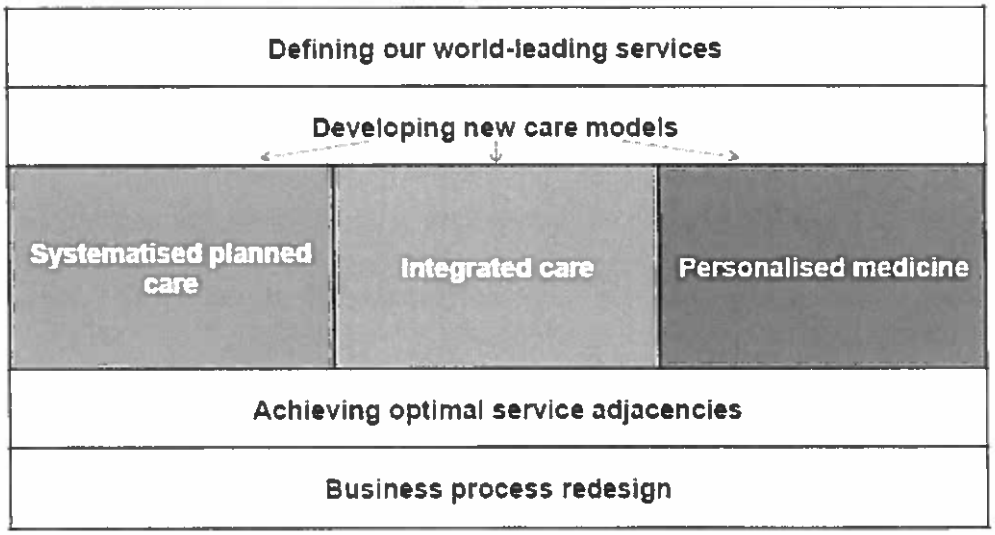
4.8 We understand local people take a close interest in what happens to hospitals and other health services in their area and want to know what they should do in an emergency, or where they should go if they need regular, hospital care. None of our plans mean cutting back on NHS care – it's about providing care differently so that you get the right care in the right place at the right time.

4.9 The clinical strategy focuses on transforming services through the implementation of new models of care to ensure our services achieve the best outcomes, are joined up, tailored to individual needs and provide an excellent patient experience. It also reflects the wider service change programme for North West London, 'Shaping a healthier future'. This programme, led by local commissioners, was approved by the Secretary of State for Health in October 2013 following a full public consultation and a review by the Independent Reconfiguration Panel. Our clinical strategy is in line with the 'Shaping a healthier future' programme.

4.10 The 'Shaping a healthier future' programme's four main principles are:

- Localisation of routine medical services will mean patients have better access closer to home with improved patient experience
- Centralisation of most specialist services will mean better clinical outcomes and safer services for patients
- Where possible, care should be integrated between primary and secondary care, with involvement from social care to give patients a fully co-ordinated service
- The system will look and feel personalised to patients – empowering and supporting people to live longer and live well.

4.11 We have established a framework setting out the core elements of the clinical transformation that we need to achieve in order to meet the very significant challenges facing health systems in general and the particular challenges facing us and North West London – these are set out in the diagram below:



4.12 Successful programmes have shown that high-quality interventions that support patients before they become acutely unwell can reduce non-elective admissions and slow progression of a disease. This can contribute to a reduction in overall care costs through the removal of acute beds when out-of-hospital solutions are in place.

4.13 When we make changes to bed numbers at our hospitals, we make these decisions based on what services the hospital provides as well as how many people need them. When people hear bed numbers are reducing, it does not necessarily mean

planning to treat fewer people – it means treating people in a different way or different place.

4.14 The proposed number of beds at our main hospital sites by 2020 (with the current numbers in brackets) is shown in the table below:

Hospital	Total	Inpatient beds	Day-case beds
Charing Cross	150*	24 (360)	86 (41)
Hammersmith	466	427 (406)	39 (39)
St Mary's	540	507 (401)	33 (40)
Total	1,156*	958 (1,167)	158 (120)

* In the space requirements and costings for Charing Cross Hospital, we have also allowed for a further approximately 40 beds to support a new integrated care offering.

4.15 Strategies for each clinical service feed into and out of the overarching clinical strategy framework. Knowledge and views at a service level have been explored in detail to ensure we have the most accurate information and assumptions about future need, optimal clinical adjacencies, new models of care, opportunities for consolidation and collaboration, and potential in terms of education and research.

4.16 The majority of the service strategies have arrived at a firm clinical consensus about the best models of care and clinical adjacencies within the clinical strategy framework.

4.17 The details for two specialties are awaiting the outcome of external developments. In emergency services, we are awaiting further guidance from NHS England on a national strategy to help guide the development of emergency services appropriate for a local hospital, specifically for our new local hospital at Charing Cross. As such, we can confirm that no decisions have been made about the future of A&E services at Charing Cross Hospital and we have no plans to close the A&E department. In orthopaedics, we are awaiting further developments on the proposal for an elective orthopaedic centre for the region at Central Middlesex Hospital.

4.18 The full clinical strategy can be read on the Trust website: www.imperial.nhs.uk

5. Outline business case for estates development

5.1 Implementation of the Trust's clinical strategy will require a fundamental overhaul of our physical estate. Detailed work has been undertaken to develop the OBC to begin the process to secure the capital funds for redevelopment of our estate in the best way to deliver our clinical strategy through a three-site model.

5.2 Our preferred option would see significant redevelopment and new build on the St Mary's and Charing Cross sites, with Western Eye Hospital relocating to the St Mary's site, and a smaller redevelopment on the Hammersmith site (where the Queen Charlotte's and Chelsea Hospital would remain co-located).

5.3 Under our plans, we would redevelop our sites: selling off some of our surplus land, but using this money to reinvest in the same sites – redesigning and rebuilding them

so they cater better to healthcare needs. It means investing: £150 million in the redevelopment of Charing Cross Hospital; £500 million on redevelopment of St Mary's Hospital; and, £10 million on development at Hammersmith Hospital. Taking planned income from surplus land sales into account, we will need additional investment of over £400 million.

5.4 When the Trust board agreed the clinical strategy in July 2014, it also approved its development in co-production with our healthcare teams, our commissioners and its implementation through the clinical transformation programme as part of the OBC.

5.5 We are currently awaiting the next stage in our bid for capital investment to fund our proposed estates redevelopment that will be a key enabler of our clinical strategy. North West London clinical commissioning groups (CCGs) have worked though all of the capital bids that flow out of the 'Shaping a healthier future' programme to create an overall 'Investment Making Business Case' (IMBC). This IMBC is currently awaiting approval by the CCGs and is then due to go to NHS England and the NHS Trust Development Authority for consideration.

5.6 We are still some way off clarifying what our new models of care should look like in practice on the Charing Cross Hospital site in order to meet changing needs. That has to be the priority before we begin to consider in detail, the design of the proposed new facilities and the sale of surplus land. So more clarity needs to be established on how the new models of care will work in practice at Charing Cross Hospital before we can progress design work on that site. And we have committed to involving patients, local communities and other stakeholders in that process too.

5.7 Meanwhile, we have also undertaken some more detailed design work with clinicians on the St Mary's Hospital estate proposals, looking to have plans to share more widely in the coming months.

5.8 Development milestones include the anticipated approval of the OBC in 2015/16 followed by the development and further approval of the final business case towards the end of 2016/17. This would enable a three-year construction programme to begin which is currently expected to last until the end of 2020/21.

6. Engagement plans

6.1 Our Trust Board agreed an extensive engagement programme to be rolled out from Spring 2015 to facilitate discussions between our clinicians and local patients and residents about how we think services should change further in the future and to better understand local concerns and ideas.

6.2 This engagement programme will begin a more structured, two-way discussion with our patients and communities to better understand their needs, concerns and priorities for future health care.

6.3 Over the past three years or so, our eight local CCGs have led a wide range of public engagement activities to inform the 'Shaping a healthier future' programme, while the Trust has also undertaken a formal public consultation on our proposal to become a foundation trust.

6.4 However, feedback from our various audiences and stakeholders indicates that we have not engaged patients, the public and other stakeholders enough on how our care is evolving in order to meet new needs and how we propose to develop services further in the future. Specifically, we have not explained clearly enough what the clinical developments will mean in practical terms for our patients and local people, nor indicated the main reasons for putting our clinical strategy in place.

6.5 This engagement programme aims to initiate a public conversation about how our care is changing. Senior Trust clinicians, alongside partners including GPs and social service colleagues, are developing a set of materials (including infographics and presentations) to help visualise how our clinicians think care needs to change over the next five to ten years.

6.6 To make this meaningful, we are looking at what the changes will mean in practice for individuals who need care within three broad service areas initially as examples. These service areas, selected to cover a range of population groups and different types of health care needs, are:

- Maternity
- Paediatrics
- Cancer

Followed by two further areas:

- Planned surgery
- The frail and the elderly

6.7 As a part of a broad range of outreach activities, for each of the selected services clinicians will, working in co-ordination with CCGs and Healthwatch, ask existing local groups of residents, patients and others to participate in sessions. These sessions will:

- Set out what care options or 'pathways' will look like across the whole 'system' - from health promotion, disease prevention or investigating symptoms through to treatment, follow up or ongoing management
- Demonstrate the common 'building blocks' of the new models of care (for example, one-stop diagnostic clinics, community-based integrated care hubs, e-consultations, genomics, care navigators, advanced day-case surgery)
- Summarise key evidence for the value of the approach
- Demonstrate examples of where some of these approaches are already in place and proving to be effective – within the Trust and elsewhere in the UK or internationally
- Share the likely timescales as they evolve for achieving the changes, at scale, and what will need to be in place to make them fully effective, including changes to our estate, transport and information technology.

6.8 We also aim to raise awareness and understanding, and to seek feedback, through our website, social media and traditional media. Depending on feedback from our key audiences, we will look to develop and roll out similar materials and sessions for other population groups and needs.

6.9 The engagement around our clinical services will inform the continual development of our clinical strategy and merge into further detailed engagement and consultation

about proposals for our buildings and facilities as and when we reach the relevant stage in our design and planning development timetable.

6.10 It is hoped that this programme will contribute to the development of ongoing public and patient engagement and instigate open discussion which will continue into the future.

7. Integrating community services

7.1 It is the Trust's aim to provide the type of services that allow people to stay healthier for longer, and avoid needing to be admitted to hospital by helping people manage their conditions well in their community and at home.

7.2 We have recently won tenders to lead a number of community services across the tri-borough area from April 2015. This includes services where we will work with GPs to provide more specialist care in the community as well as a new initiative, the community Independence Service, financed through the Better Care Fund, where we are leading a network of health providers to work in partnership with a lead social care provider to help mainly frail, elderly people stay well and get well, out of hospital.

7.3 We were also awarded the contract to provide the Hammersmith and Fulham community gynaecology service. The service will operate from Charing Cross Hospital from March and Park View Clinic in White City from April 2015, providing care for about 3,500 women annually.

7.4 The service, building on an existing pilot, will provide the first level of care for all women across the borough referred for non-urgent gynaecological problems. The new service aims to support early intervention in primary care and improve access by increasing the level of care available to women in the community. If patients referred to the community service do require further specialist investigation or treatment, they will be referred on to the secondary care service of their choice.

8. Changes to urgent and emergency services

8.1 Changes to Hammersmith Hospital urgent and emergency care services took effect on 10 September 2014. These changes formed an initial part of 'Shaping a healthier future', the major programme led by clinicians to improve health services in North West London.

8.2 These changes to urgent and emergency care are intended to ensure we have high quality specialist services where they are most needed. We can provide better care, more sustainably, by concentrating more resources for seriously ill and injured patients at St Mary's Hospital and Charing Cross Hospital while ensuring good local access for those with urgent but not life-threatening conditions at our urgent care centres, including the expanded centre at Hammersmith Hospital. We know that we are saving more lives through this sort of approach for major trauma, strokes and heart attacks.

8.3 It should be noted that the Independent Reconfiguration Panel (IRP) in its advice on the 'Shaping a healthier future' proposals submitted to the Secretary of State for Health in September 2013, said:

> "The Panel agree with the widely held view that the status quo is neither sustainable nor desirable. The Panel is also concerned that the current position is not stable. Some acute services, including A&E, are already at risk from increasing specialisation in surgery and shortages in supply of key clinical staff. The Panel is clear that the continuing safety and quality of some acute hospital services are a real and current risk for the NHS that should inform the priority and timing of service changes in the *Shaping a Healthier Future* implementation programme."

8.4 In specific reference to the emergency unit at Hammersmith Hospital, the IRP went on to state in the same report:

> "With regard to the existing A&E at Hammersmith Hospital, the Panel found that, while residents considered it to be a valuable service, the range of conditions able to be treated is constrained by the absence on-site of relevant back-up services such as emergency surgery. Both the commissioners and the provider of this service agree that better care could be provided by concentrating A&E resources at St Mary's Hospital linked to a 24-hour urgent care centre at Hammersmith Hospital."

8.5 In May 2014, the Trust's board approved the planned closure date for Hammersmith Hospital's A&E of 10 September 2014. Assurance was undertaken by Hammersmith & Fulham CCG, NHS England and the NHS Trust Development Authority, the 'Shaping a healthier future' programme, and the Trust to ensure the changes were implemented safely.

8.6 The urgent care centre at Hammersmith Hospital expanded on 23 June 2014, to be open 24 hours a day, seven days a week, in preparation for the closure of the hospital's A&E department. More than half the patients who attended Hammersmith Hospital's urgent or emergency services were seen at its urgent care centre, and these patients can continue to be treated there. The London Ambulance Service was involved in the planning of the changes to ensure that all patients continue to be transported to the most appropriate hospital depending on their condition.

8.7 Anyone who self-presents at Hammersmith Hospital and is found to have a serious condition will receive immediate care and be transferred by London ambulance to the A&E or specialist unit most suitable for their health needs. Patients suspected of having a heart attack continue to be taken straight to Hammersmith Hospital which has one of London's eight heart attack centres, providing specialist emergency care 24 hours a day, seven days a week, for people in west London suffering heart attacks or arrhythmia.

8.8 The main priority in implementing the changes to A&E services at Hammersmith Hospital was patient care and safety and detailed planning for the changes was put in place. The new processes and services were tested to ensure safe high quality care. Patient activity and performance continue to be closely monitored after the changes have taken effect.

8.9 The changes that were implemented at the Hammersmith Hospital site to ensure readiness for the transition were as follows:

- Urgent care centre operating on a 24 hours a day, 7 days a week basis from 23 June 2014
- Transition to London Health Programme standards completed by September 2014
- Opening of a 24/7 specialist medicine assessment centre consisting of 11 trolleys
- Introducing a new medical telephone line to facilitate GP urgent medical referrals, with the exception of haematology and renal where direct referral to specialist units take place. This telephone number is for urgent medical referrals to Charing Cross, Hammersmith or St Mary's Hospitals.
- Launching a hub for specialist medical referral service 12 hours a day 7 days a week
- Opening of a discharge lounge
- Enhanced level 1 ward with full monitoring and capability for non-invasive ventilation
- Hammersmith Hospital clinical pathways tested and reviewed with clinicians.

8.10 Additional capacity reflecting the case mix at Hammersmith Hospital was created at St Mary's Hospital, Paddington. The changes implemented at the St. Mary's Hospital site to ensure readiness for the transition of A&E services from Hammersmith Hospital were as follows:

- New unit for ambulatory emergency medicine opened
- Additional 15-bed medicine for the elderly ward opened
- Reconfiguration of emergency department to optimise resuscitation / high dependency unit capacity and increase the number of cubicles by two
- Medical assessment unit pathways reviewed
- St. Mary's Hospital linked to the special medical referral service
- Three additional core medical trainees added to the acute medical team
- Six additional band 5 nurses recruited for the emergency department
- Two additional clerical staff appointed to enable weekend and evening working on the admission wards
- Emergency nurse practitioners hours extended to 12 hours since early July 2014
- Six additional A&E consultants recruited.

8.11 While it was anticipated that most of the patients who would previously have been treated in Hammersmith Hospital's A&E would go to St Mary's Hospital's A&E, the Trust also expanded capacity at Charing Cross Hospital's A&E as part of the preparations.

8.12 The changes implemented at the Charing Cross Hospital site to ensure readiness for the transition of A&E services from Hammersmith Hospital were as follows:

- Relocation of the ambulatory care unit to increase medical assessment unit capacity by four beds
- Relocation of the older persons rapid assessment clinic (OPRAC) service to a dedicated frailty unit with additional capacity
- Charing Cross Hospital linked to the specialist medical referral service
- Three additional core medical trainees added to the medical team working across OPRAC, ambulatory care and acute medicine
- Three additional band 5 nurses recruited to the emergency department

- Appointment of a new role of pathway co-ordinator to help patient flow both into and out of the hospital.

8.13 A major public awareness and information campaign took place throughout August-September 2014 to ensure local people knew where to access healthcare urgently or in an emergency.

8.14 The changes across the three Trust sites have continued to be monitored closely, both by the Trust and by commissioners. There is a set of agreed clinical quality standards and regular monitoring is in place to provide evaluation and ensure patient care remains safe and of a high quality. This includes monitoring patient and staff feedback on the changes.

9. Winter resilience planning

9.1 As in previous years, we developed and implemented plans for managing the additional challenges for health and health care that the winter season brings. This was especially important as, in common with other trusts across London and other parts of the country, we had already experienced increased pressure on our A&E services in the run up to winter.

9.2 Across the Trust, we have had slightly more beds open than we did during the previous winter and we have worked in partnership with NHS, local authority and other partners to help patients stay well or recover at home or in the community wherever possible.

9.3 Key winter resilience initiatives put in place include:

- At Charing Cross Hospital, opened an 18-bed 'intermediate care' ward to support patients who need short-term rehabilitation or recuperation
- Older people's rapid assessment service at Charing Cross Hospital extended to seven days (from five)
- Cancer assessment unit at Charing Cross Hospital extended to seven days (from five)
- Additional six emergency consultants in place from mid-December across Charing Cross and St Mary's A&E departments
- Recruiting additional acute medicine physicians starting during Quarter 4 of 2014/15
- Additional 12 medical beds opened at St Mary's Hospital from early January 2015
- Extra support from the central discharge team and better integration with additional community support for seven-day discharge
- Staff flu campaign – 6,000 flu vaccines

10. A&E performance and additional actions

10.1 From our own detailed analysis of our patient flows, we can see that the increases in attendances at St Mary's and Charing Cross A&Es are actually below the increases anticipated – and planned for - following the closure of the A&E at Hammersmith Hospital in September 2014. For example, at St Mary's Hospital we planned for 60

extra attendances per day in October-December 2014 compared to October-December 2013, but received 28.

10.2 There appears however, to be a trend for much larger and more varied peaks in day-to-day attendance as well as for the patients who are attending to be more seriously ill. At St Mary's Hospital the standard deviation (statistical measure of variation) of daily attendances between November-January 2014/15 increased by 20 per cent compared to the same period the previous year. Between October-December 2014, average Category A Ambulance Conveyances to St Mary's Hospital increased by 10 per day compared to the previous year, a rise of 33 per cent.

10.3 We are also seeing challenges across our hospitals in being able to get patients home or into more local care when they are medically fit and no longer need to be in an acute hospital. Length of stay at St Mary's Hospital increased between September-December 2014 by an average of 1 day, despite reductions during 2013 and stability during 2014. This has been driven by a 22 per cent increase in the number of patients with a length of stay over 14 days during the same period and a 60 per cent increase in the number of delayed repatriations to patients' local hospitals after specialist treatment at St Mary's Hospital. Between January-August 2014 there was an average year on year increase of two extra beds occupied by patients with delayed repatriation from St Mary's Hospital to their local hospital. This increased to an average year on year increase of six extra beds occupied by patients with delayed repatriation between October-December 2014.

10.4 The combination of higher attendances and admissions, many at higher acuity and patients with longer length of stay, has resulted in an increase of emergency care patient occupancy at St Mary's Hospital. In response, capacity throughout the hospital has been impacted and the flow of patients through the emergency pathway, irrespective of whether they were being admitted into the hospital, slowed down. This has resulted in longer wait times and an increase in the number of patients breaching the four hour emergency care standard.

10.5 We have responded by recruiting more senior clinical staff, opening more medical beds, creating more space in A&E and working closely with partners to improve discharge arrangements. We averaged 91 per cent of all A&E patients waiting 4 hours or less in third quarter of 2014/15 (October-December 2014) against the national target of 95 per cent.

10.6 Since January, with the support of NHS England and local commissioners, we have invested above our existing recovery plan in a focused project to return us to delivering the 95 per cent 4-hour A&E wait standard. The project involves a full review of the emergency pathway from reception, triage, assessment, observation and admission through to transfer and discharge in order to identify and implement targeted improvement initiatives. Additional action has been taken in improving processes resilience and responsiveness in emergency department operations, simple and complex discharges, bed flow and management, internal delays and hospital urgency and responsiveness triggers. The project is focusing initially on St Mary's Hospital and we are now spreading the most effective initiatives across the rest of the organisation.

10.7 Other actions we have taken to ensure that we get back on track to meet the 95 per cent standard for four-hour A&E waiting times include:

- Creating more space both in A&E and on acute wards to allow patients to be admitted when they need to be and working with partners to make sure patients can be discharged home or to supported care in the community as soon as they are ready
- Moving our St Mary's Hospital urgent care centre treatment rooms to a new unit near to A&E in February to create extra space in A&E for more serious emergency cases
- Opening an additional five beds at Charing Cross Hospital in February.

10.8 The Trust is also participating in a wider independent review of A&E services across North West London which is being led jointly by NHS England, NHS Trust Development Authority, and Monitor, the aim of which is to understand the root causes for current A&E attendances, admissions and performance in order to identify the most effective system responses.

10.9 Longer term, the whole system has to respond to changing health care needs as many of those who are currently coming to A&E, especially the large number of frail and elderly people, should have more support to stay well so that they do not suffer entirely avoidable health crises.

11. Summary

11.1 Implementation of the Trust's clinical strategy will enable us to transform the way we provide our care in order to meet the changing needs of our patients in North West London and beyond. It will mean more local and integrated services, to improve access and help keep people healthy, and more concentrated specialist services where necessary, to increase quality and safety. Crucially, it will reduce hospital admissions – so that patients are only admitted to hospital when they should be. Not because we have not done enough to help them manage their long term condition at home or because we are waiting for test results to come through. And it will mean better organised care, helping us improve patient experience as well as clinical outcomes.

11.2 By 2021, we plan to have invested just over an additional £400 million – on top of reinvesting the proceeds from surplus land sales - in purpose-built or improved facilities within a three-site model – Charing Cross, Hammersmith (including Queen Charlotte's and Chelsea) and St Mary's hospitals. We will also be providing our specialist services through integrated care hubs, in community clinics and through other innovative ways of bringing our services to our patients rather than to always expect our patients to come to us.

11.3 We recognise that to develop our strategy further and to implement it successfully, we need to do much more to explain our thinking and to listen and respond to the views and concerns of patients and local communities. And we have to make sure that we have community capacity in place before we change inpatient hospital services.

11.4 Working closely with our commissioners, and building on previous engagement and consultation, we are developing an engagement programme specifically around the implementation of our clinical strategy. We will look to build awareness and understanding of the key elements of the strategy and, most importantly, bring in the views and ideas of stakeholders to help shape our future plans. This will cover new models of care, improving patient pathways and systems, and our estates design and implementation.

11.5 Last year we consistently met the 95 per cent A&E 4-hour target for all types of patients, and the measures we have put – and are putting – in place will help us to get back on target. Longer term, the whole system has to respond to changing health care needs as many of those who are currently coming to A&E should have more support to stay well so that they do not suffer entirely avoidable health crises.

NHS
Harrow
Clinical Commissioning Group

Executive Office
The Heights
59-65 Lowlands Road
Harrow on the Hill
Middlesex HA1 3AW
Tel: 020 8422 6644
Fax: 020 8426 8646

www.harrowccg.nhs.uk

23 February 2015

Dear Mr Mansfield

Re: Inquiry into the reconfiguration of hospital-based services in North West London

In accordance with the call for evidence to your inquiry, please find set out below the approach of Harrow CCG to the commissioning of health and care services for our population and a summary of developments to make more care available through primary and community health services, supporting the shift of services out of hospital settings.

Harrow CCG Governing Body believes that the reconfiguration of hospital services in North West London is essential to improving the quality of lives of Harrow residents. We are also clear that, whilst the speed of the reconfiguration represents significant challenges, all steps are being taken to ensure that this is done safely and in the interests of patients. At the same time, we are committed to ensuring that the change process is one that is open and transparent.

We are also absolutely committed to working together as a collaboration of the eight North West London CCGs and ensuring that our local plans fit in with our joint plans, which we have set out in the Shaping a Healthier Future Strategy, consulted upon and which we are now implementing.

Harrow CCG is committed to commissioning care that improves the quality of the lives of its residents. Our population is diverse, older in comparison to the rest of London (with the average age increasing) and there are inequalities in health and wellbeing with people from the poorest parts of Harrow living on average seven years less than those in the richest areas. To meet the needs of our population, we need to deliver support that is provided around people and not around existing organisational arrangements. Care must be proactive, preventative and person-centred, delivered in settings that are appropriate for the service user rather than convenient for the service.

The work being implemented across North West London through the Shaping a Healthier Future programme together with our local initiatives will improve the quality and sustainability of healthcare for our patients.

With specific reference to the closures of the A&E units at Central Middlesex and Hammersmith Hospitals we believe this was the correct clinical decision to ensure safe sustainable care to patients across North West London. The changes have created greater operational resilience which has helped the local NHS manage what is a national issue of increasing demand on urgent and emergency care services.

Developing Out of Hospital services
Set out below are a range of examples where the CCG has been working with GPs and other providers to improve the quality and capabilities of health services outside major hospitals. Working to reduce the need for people to be treated in hospitals and where it is necessary ensuring people can return home as quickly as possible.

We continue to make good progress with our out of hospital strategy, investing in a range of initiatives summarised below and are working hard to reduce the recent increase in non-elective admissions.

Our **Integrated Care Programme** has grown from strength to strength. The service currently holds over 6,000 care plans for vulnerable adults for the purposes of case management. For 2014/15, the service expanded the team to include the role of the care navigator to proactively support the management of these care plans.

We have increased the numbers of **community beds** available for Harrow residents and targeted initiatives to increase the throughput by funding enhanced discharge teams. Harrow's main community bed base has increased the number of accepted referrals from 30 to 40 per month. This has positively supported acute flow.

Our existing **community walk-in centres** have increased the number of primary care patients treated. For 2014/15 the service is now treating a forecast outturn of 14,600 treated patients from a previously planned 9,700 target. In addition to this, through our commitment to the 2014/15 Prime Minister's Challenge Fund, our primary care services will be better equipped to support patient expectations in the choice of access points i.e. telephone, online and face to face interactions in addition to commissioning a further 18,000 walk-in centre appointments in Q4 2014/15. Our longer term plan is to commission services capable of delivering a total of 36,000 walk-in appointments across Harrow.

We have commissioned and rolled out an integrated **short term intensive support and rapid response service** (STARRS) which works collaboratively across organisational and professional boundaries. Based in the hospital but working extensively with primary and community care STARRs has delivered 1,700 reductions in NEL (non-elective) admissions and 1,000 avoided A&E attendances in the last financial year. For 2014/15, we have grown this to support an additional 300 NEL avoided admissions and 150 A&E avoided attendances. This service also provides a discharge support and community rehabilitation function, which is partly responsible for the positive reduction on delayed transfers of care for Harrow residents in the last year.

Our **Urgent Care Centre** is co-located with the A&E department at Northwick Park Hospital and treats walk in minor injuries and illnesses across a range of conditions. This service was commissioned four years ago and operates 24 hours a day, seven days a week. Since the start of the contract, the service has grown from treating on average 190 patients per day to over 300 patients per day. This is supporting a reduction in the volume of activity attending A&E, allowing the A&E department to concentrate on more complex and life-threatening patient presentations. At the same time, the A&E Unit at Northwick Park has recently been expanded and re-configured to provide additional capacity and a better service.

Delayed transfers of care have received a continued focus which has resulted on average in a 50 per cent reduction in the official delays reported by our local provider, London North West Healthcare Trust.

We are also ensuring that **the views of our service users are core in shaping the services we commission.** We have undertaken a range of co-production events including an 'integration summit'. Our residents told us they wanted:

- Better access to care when it suits them
- Self-care and self-management
- Minimal handovers, which happen effectively and avoid loss of information
- To avoid having to repeat their story to multiple providers
- Support to set meaningful goals and care which is designed to help them meet their needs
- A system where the constituent parts communicate effectively with each other
- Information that is easily accessible
- Care plans which are up to date and that they have control over
- Unpaid and family carers to feel more empowered and able to provide day-to-day care

These are the principles on which our **integrated care delivery model** is based and we will continue to test our work with our residents as we roll out our new models. For 2015/16, Harrow is embarking on an exciting programme as part of our Out of Hospital Strategy. This includes:

- Setting up a single Harrow-wide GP Provider Network which will support the integration of primary care services. Our aim is that this will provide a structure to support primary care to manage current/future demand levels and have the ability to work collaboratively with partner services.
- Expanding Harrow's community walk-in centre provision by developing new sites to provider a better coverage of the service and commission all sites to a uniform 8am to 8pm seven day service model. This will support the Prime Minister's Challenge Fund objectives.
- Re-procuring our community services in 2015/16 to deliver community services which are more integrated with primary and intermediate care services.
- Expansion of the "Whole Systems Model of Care" to proactively case manage our vulnerable older population through the employment of enhanced health, social and voluntary sector teams.
- Building on the strengths of the existing integrated approach to mental health and dementia and providing support for carers.

Key to the reconfiguration of hospital services for Harrow residents has been a partnership approach, involving Harrow Council, key providers, patients, Healthwatch Harrow, representatives from the voluntary sector, GPs and the CCG. A recent success of this collaborative approach has been approval, without conditions, of the Harrow Better Care Fund Plan. Set out in the plan are ambitious proposals to achieve:

- 3.5 per cent reduction in non-elective activity for 2015/16 against the 2014/15 baseline. This will be delivered through our intermediate care service (admission avoidance), increasing activity directed to the Ambulatory Emergency Care Unit for a day case outpatient treatment service, and through the development of a new team to actively case manage patients as part of a multidisciplinary team within the "Whole Systems Integrated Care" scheme.
- One per cent reduction in delayed transfers of care across the targeted years

- Maintenance of the percentage of permanent admissions to residential and nursing homes for over 65 year olds whilst expecting a growth in the population.
- Maintenance of the proportion of older people (over the age of 65 years) still at home 91 days after discharge from hospital into reablement /rehabilitation
- An increase from £3.56 million in 2014/15 to £5.411 million in the funds allocated to protect social care.

In conclusion, the quality of life and care we, as GPs, want for residents – our patients – can only be delivered if we transform existing ways of working and remove entrenched organisational barriers. Settings of care will, and must, become less important as service users increasingly direct their own care in a way that meets their needs and delivers the outcomes that matter to them. Harrow CCG will continue to work with partners from across the system to ensure that this is achieved in a safe, effective and sustainable way.

Yours sincerely

Dr Amol Kelshiker
Chair, Harrow CCG

NHS
Hillingdon
Clinical Commissioning Group

Boundary House
Cricket Field Road
Uxbridge
Middlesex
UB8 1QG

Tel: 01895 203000
Fax: 01895 203010
www.hillingdonccg.nhs.uk

23 February 2015

Dear Mr Mansfield

NHS Hillingdon CCG submission

I am writing to you as Chair of Hillingdon CCG to set out information that NHS Hillingdon CCG (the CCG) feels is relevant to the review you are currently undertaking into A&E closures in September 2014 as part of the Shaping a Healthier Future (SaHF) programme. In particular I would like to draw your attention to the following points:

- We believe the closure of the two A&E departments (replaced by 24/7 365 day Urgent Care Centres) was the clinically correct decision to provide a sustainable high quality emergency care service around the clock across North West London.
- We believe further delay in the SaHF programme would be the worst of all options creating genuine clinical risk and instability in services which need to be improved for our patients.
- We do not believe that the A&E closures at Central Middlesex Hospital or Hammersmith Hospital have contributed to winter pressures in Hillingdon. Pressure was primarily from within our own borders.
- We believe further investment in our local hospital infrastructure is needed as we progress with planned changes.

Background information
I would like to bring to your attention some key points about Hillingdon and the context for SaHF in this borough.

Hillingdon has one main acute care provider (The Hillingdon Hospitals NHS Foundation Trust), one community and mental health provider (Central North West London NHS Foundation Trust) and is coterminous with the Local Authority (LA). This supports close and collaborative working across the local system.

Hillingdon is geographically large (2nd largest borough in London) with Heathrow airport in the south of the borough. It has the 13th largest population in London. From mid-year 2015 to mid-year 2021, the population is projected to increase by 8.6% to 320,000 with the majority of this increase in the 5-17, 25-39 and 40-64 year age bands. We also anticipate an increase in the BME groups from 48% in 2011 to 50% in 2015 with much of this change happening in younger age groups. We

anticipate associated increases in the prevalence of long term conditions. For example modelling suggests an 8.2% prevalence rate for diabetes in the borough although currently the diagnosed prevalence rate is 6.4%. We are also expecting to see an increase of more than 15% in dementia rates from 2014 to 2021.

Meeting changing needs

The CCG expects to meet these changing needs through reconfiguration of acute services and development and investment in our Out of Hospital (OOH) strategy.

The Joint Committee of PCTs approved the Shaping a Healthier Future programme as, based on the evidence and clinical opinion, the existing configuration of acute hospitals could not meet the changing needs of our population going forwards. A reduced focus on hospital based care is required with far more care being provided in community settings in a manner that also supports patients to manage their own long term conditions (LTC) and maintain their independence for as long as possible.

To enable the SaHF acute reconfiguration programme to be delivered, Hillingdon CCG developed an Out of Hospital (OOH) strategy that was agreed in 2012 (Hillingdon CCG OOH Strategy). The OOH strategy focused on five strategic aims:

a) Easy access to high quality and responsive primary care
b) Clearly understood planned care pathways
c) Rapid response to urgent needs
d) Providers (health and social care) working together to proactively manage LTCs, the elderly and end of life care
e) Appropriate time in hospital with early supported discharge.

Achievements so far against these areas are set out below:

a) **Primary care** - In 2014/15, Hillingdon CCG received an allocation of just under £1 million from the Prime Minister's Challenge Fund (PMCF) which has been used as enabling funding to support improved access for patients to GP practices. There are now 6 GP networks in Hillingdon (two of which are involved in our Whole System Integrated Care Pioneer programme). A number of the networks are participating in the Productive Practice programme that is designed to create capacity in general practice through more efficient working. In addition, networks have submitted bids to receive funding for initiatives that improve access and care for defined population groups. In 2015/16 we have been allocated further PMCF funding that will contribute to CCG investment plans to extend access to primary care services. We have an agreed primary care development plan in place that addresses all areas of primary care including workforce, education and infrastructure (Primary Care Delivery Strategy).

b) **Planned care pathways** – In 2013/14 and 2014/15 the CCG in collaboration with its providers has redesigned and implemented 7 planned care pathways leading to a reduction of approximately 2774 first outpatient appointments and approximately 7397 follow up appointments. The focus on these services (MSK, ENT, gynaecology and urology) in the current and next year is to provide them from more sites in the community. Dermatology and Ophthalmology are already provided in community settings.

c) **Unplanned Care** – The CCG has put in place a range of admission avoidance schemes designed to reduce pressure in A&E and to support patients (particularly the elderly) to be supported at home thus maintaining their independence and support networks. A 24/7 Urgent Care Centre (UCC) was opened in October 2013 at the Hillingdon Hospital and now sees at least 60% of all attendances at the A&E department which releases A&E staff to focus on people with the most acute problems. The work of our Rapid Response service, Age UK and the CNWL Home Treatment Service for older people currently supports 5 people a day to avoid an unplanned admission via A&E with this figure expected to rise to 7 a day in 2015/16. The service receives referrals from A&E, GPs, London Ambulance Service and Care Homes. In addition, the hospital has increased use of Ambulatory Emergency Care Pathways that now helps 270 patients per month to avoid admissions (OOH Strategy). The recent opening of the new Acute Medical Unit next to the A&E department is also supporting improved pathways of care and reducing the length of time people need to stay in hospital.

d) **Integrated services** –

Long Term Conditions (LTCs) - During this year the CCG has also been developing new integrated pathways for Cardiology, Respiratory conditions (COPD & Asthma) and Diabetes with the focus on improving outcomes for patients by reducing the number of exacerbations they experience and empowering them to take control of their condition more effectively. The work is being implemented across acute, community and primary care health services with more care being provided in community settings. There is also a programme to support people to manage their own care more effectively. Hillingdon currently has an estimated 91,000 people living with one or more LTC and in total this costs the health economy between £91m and £116m. According to public health up to 1 in 3 patients that occupy a bed are there because of an LTC or for co-morbidities associated with their LTC. The fact that a patient with an LTC can be admitted for co-morbidity rather than their primary disease blurs the figures but patients with LTCs could account for up to 50% of all unplanned attendances at A&E. Our work on Integrated Pathways is in its first year and collectively our work is expected to reduce emergency admissions by 300, first outpatient appointments by 750 and follow up appointments by 1950. (OOH Strategy).

Older people – Older people are the focus of our work on the Whole System Integrated Care pilot in the north of the borough and our Better Care Fund (BCF) plans with the Local Authority. As noted previously, the co-terminosity of providers, CCG and LA supports an integrated approach to care and our main providers and a voluntary sector consortium are fully engaged in our Whole System Integrated Care Pioneer programme.

The Hillingdon BCF plan has a total value of £17.9 million and will facilitate a shift to planning for anticipated needs rather than crisis response, with physical and mental health and social care needs of residents met via services that are integrated and seamless from a service user perspective. Key programme areas include joined up intermediate care, early identification of people with falls, dementia and social isolation, better end of life care, seven day working and reducing avoidable care home admissions. This is underpinned by joint working to implement wider Care Act duties and improve information sharing and enhance care planning. All of the areas listed are already underway and are expected to deliver a reduction of 3.5% in NEL admissions in the over 65 year age group.

Hillingdon CCG and LBH will continue to work collaboratively to develop health and care plans, building on our BCF plan which will commence in April 2015. Our ambition for the BCF plan is to ensure residents can plan their own care, working with professionals to understand their needs so they have control over services and that these deliver what is important to them. This will require system change and further integration across health and care services. In addition to the BCF, the Hillingdon Transformation Programme comprising all key partners, ensures alignment of the BCF plan with wider plans including unscheduled care, mental health and primary care

End of Life Care – Hillingdon CCG already supports high numbers of people (between 45 and 50%) to die at home if this is their preferred place.

In addition to the areas identified above the CCG and Local Authority have agreed 3 year priorities for mental health services and in 14/15 developed a range of new mental health services in the borough (Hillingdon CCG Commissioning Intentions).
These include psychiatric liaison services, enhancing perinatal pathways, building capacity in dementia care, a new community crisis home treatment team for older people and enhanced capacity community Child and Adolescent Mental Health Services (CAMHS).

We are also developing three "hubs" across the borough. These hubs will provide a base for the delivery of Out of Hospital services and the delivery of integrated care. The first hub has been developed in the south of the borough with two further hubs identified.

e) **Appropriate time in hospital** – Our plans for 15/16 include enhancing our support to Care Homes (which already includes two Community Matrons who work directly with vulnerable patients) through establishing a community based geriatrician. We are also continuing to invest in our Home Safe scheme that provides early supported discharge support for people aged 65 years and over. (Hillingdon CCG Strategic Service Delivery Plan).

As can be seen from the information above, we have made excellent progress with implementation of our OOH strategy to support safe implementation of the SaHF programme.

Engagement with patients and carers

Patient, carer and public engagement is seen as key to supporting and informing commissioning decisions and the CCG have taken active steps to strengthen its approach to engagement. The CCG tailors its engagement programmes to reach as many people as possible based on the equality impact analyses carried out ahead of any service redesign. For example, a recent public consultation to inform our Dermatology procurement received feedback from 400 patients and carers. Of these 84% supported the CCG's proposals to establish a community service.

We also monitor the impact of our service changes and have commissioned our local Public Health team to carry out a Health Impact Assessment on our service redesign programmes.

Hillingdon CCG also works with the seven other CCGs in North West London to deliver SaHF and the Whole Systems Integrated Care programme. These programmes have strong patient engagement and involvement from Hillingdon. Healthwatch Hillingdon, individual patient and carer representatives have been involved in the programme to enable engagement, where relevant to be carried out across boundaries to follow patient activity and support choice. The emerging GP networks are also being supported to ensure they have appropriate patient engagement and involvement during the coming year.

Impact of the Hammersmith Hospital and Central Middlesex Hospital A&E closures

The CCG does not believe that the closures have contributed to rising demand at Hillingdon A&E. In common with the rest of the country, Hillingdon CCG has seen a significant increase over 2014/15 in non-elective attendances and admissions. Significant work has been undertaken to understand the drivers for this increase and a three pronged action plan agreed with Hillingdon Hospitals Trust to address the issues. Our work has demonstrated that almost all of the Hillingdon increase has originated from within the Hillingdon borough i.e. we have not seen significant increases in people attending our A&E from outside of the borough as a result of the closure of A&Es at Hammersmith Hospital or Central Middlesex Hospital.

Conclusion

In conclusion I would like to confirm that Hillingdon CCG remains fully committed to the SaHF programme. The proposals have been fully scrutinised by local clinicians from across the health system, the Independent Reconfiguration Panel, the High Court and the Secretary of State. The CCG continues to believe the SaHF programme is absolutely necessary to secure a sustainable and safe health service in North West London in the long term. We believe that delay in implementation represents the worst of all possibilities.

Yours sincerely

Dr Ian Goodman
Chair Hillingdon CCG

NHS
Brent
Clinical Commissioning Group

Wembley Centre for Health & Care
116 Chaplin Road
Wembley
Middlesex HA0 4UZ
Tel: 020 8795 6485
Fax: 020 8795 6483
www.brentccg.nhs.uk

23 February 2015

Mr M Mansfield
c/o Mr Peter Smith
London Borough of Hammersmith & Fulham
Room 39
Hammersmith Town Hall
King Street
London
W6 9JU

Email: peter.smith@lbhf.gov.uk

Dear Mr Mansfield

This letter is in response to your call for evidence to your inquiry into the closure of the Accident & Emergency (A&E) Departments at Central Middlesex Hospital (CMH) and Hammersmith Hospital (HH).

Brent CCG along with other NHS and non-NHS organisations is responsible for the delivery of healthcare services for the population that it serves, and as co-ordinating commissioner for London Northwest Healthcare NHS Trust (LNWHT) was responsible for overseeing the safe closure of Central Middlesex Hospital A&E department.

In order to address this complex issue comprehensively, we have set out the evidence provided in this letter under a number of key headings which describe:

- An overview to the population of Brent and the particular health challenges we need to plan and commission for in the years ahead
- Local background and context to the reconfiguration of A&E services, and Brent CCG's role in the planning and assurance of the closures of the A&E departments at Central Middlesex and Hammersmith hospitals
- The improvements being made in Out of Hospital care within general practice and the wider community based health services evidencing progress in our ability to reduce dependence on acute hospital based services

The changes we are implementing are designed to prevent illness by providing proactive care and earlier intervention to reduce the reliance on emergency care and to keep our population healthy in the community.

Brent CCG believes the transformation of A&E services across North West London has been the right thing to do to improve the clinical safety of the services and improve the quality of outcomes available 24/7 to all residents of North West London.

Brent CCG is confident in its assurances that the A&E departments at CMH and HH closed safely and effectively on 10 September 2014 as planned. These changes are not, in Brent CCG's view, the cause of the recent pressures on A&E performance seen at LNWHT, across London and nationally. Rather, these changes have created greater operational resilience in the North West London urgent and emergency care system. This is supported by NWL demonstrating the best A&E performance metrics across London in quarter three of 2014/15, despite the increase in demand.

OVERVIEW AND STRATEGY

Brent CCG is committed to commissioning care that improves the quality of the lives of its residents. Brent is ranked amongst the top 15% most deprived areas of the country. This deprivation is characterised by high levels of long term unemployment and low average incomes supported through benefits and social housing. A third of young children are living in a low income household. Living in poverty generally contributes to poorer health. We have significant health inequalities with a significant life expectancy gap of 5.3 years in men between the most affluent and most deprived parts of the borough. Cardiovascular disease, chronic respiratory disease and cancers are our biggest killers. Our rate of diabetes is high, with 23,000 patients registered with diabetes.

The Brent population of 325,000 is rising. The most recent Health and Social Care Information Centre (HSCIC) data in January 2014 indicates that the Brent General Practice (GP) registered population is 355,337. Although the population of Brent is younger than England generally, the population aged 65 and above will grow at a faster pace than the population at large. Between 2011 and 2021 the population aged between 65 and 74 is expected to grow by 16%, 75-84 by 16% and 85+ by 72%, whilst the total population will only grow by 7%[1].

To address the needs of our population Brent CCG, in collaboration with the other seven CCGs across North West London, has developed ambitious plans to ensure that the Brent population of 325,000 and the wider North West London population of two million people has access to 24/7 high quality, improving and sustainable healthcare services.

Brent CCG recognises the need to deliver care differently to ensure services meet the changing health needs of the population and in a manner that is sustainable for the future. We have worked with our stakeholders locally and across North West London to develop our plans which are now being implemented to provide proactive care that prevents ill health and reduces our reliance on emergency care by keeping patients healthy in the community. These plans include: the reconfiguration of hospital based services, the implementation of whole systems integrated care and the transformation of primary care services. Brent CCG is committed to ensuring that local patients have access to high quality care that is fit for purpose for the next decade and beyond.

[1] Office of National Statistics 2011 based population projections

In order to deliver these plans, Brent CCG and the other seven CCGs across North West London are implementing proactive, preventative and person-centred care which is delivered in settings that are local, accessible and appropriate for the service user. Brent CCG's delivery of proactive and preventative community based care is well underway (see below Out of Hospital developments), as is the case for the other seven CCGs across North West London.

RECONFIGURATION OF HOSPITAL BASED SERVICES

The reconfiguration of hospital based services across North West London described in Shaping a Healthier Future (SaHF) was approved by the Joint Committee of Primary Care Trusts in February 2013, following a robust and rigorous consultation process. The rationale for this reconfiguration was to ensure that all patients have access to 24/7 high quality care. It was recognised that reducing down from nine major acute hospital sites across North West London to five would achieve this and as a result improve outcomes for patients and save lives. This is evidenced and supported by the centralisation of specialist services that had previously been undertaken, namely the centralisation of Hyper Acute Stroke Units and Heart Attack Centres in London and from other examples of centralisation elsewhere. Brent CCG, along with the other seven CCGs across North West London, is committed to the reconfiguration programme and its underpinning transformation of primary care services and delivery of whole systems integrated care. These three key deliverables will provide improved services for patients and save lives and it is therefore imperative that we commit to and deliver these necessary changes as soon as possible. This will ensure that the Brent population and the wider North West London population has access to 24/7 sustainable high quality care, given the need to deliver this in more efficient and cost effective ways due to the financial pressures of an ageing and growing population. Any delay to the delivery will hinder our ability to provide better care and save lives.

The decision of the Joint Committee of Primary Care Trusts in February 2013 was subject to a review by the Independent Reconfiguration Panel (IRP). On the advice of the IRP, the Secretary of State (SoS) for Health supported the Shaping a Healthier Future programme recommendations in full and also made further recommendations in October 2013 which included the proposed A&E closures at Central Middlesex and Hammersmith Hospitals, to state that these "should take place as soon as practicable". The programme therefore proceeded with implementing these changes as local clinicians strongly supported the SaHF programme and SoS decision.

As a result, in January 2014, projects at both Central Middlesex and Hammersmith Hospitals were set up to ensure the planned and safe closure of the A&E departments at the respective sites, overseen by the Trusts; Imperial College Healthcare Trust (ICHT) and London North West Healthcare NHS Trust (LNWHT) [previously North West London NHS Trust and Ealing Hospital NHS Trust], CCGs, NHS England and Trust Development Authority. Following discussions, it was agreed that the A&E departments should plan to close at the same time (as this would cause less confusion for the public and patients and prevent displacement of activity to the other site if one closed ahead of the other), and ahead of the winter period (to avoid the time of year when Trusts and A&E departments are busier). A date of 10 September 2014 was agreed, subject to a full and rigorous assurance process which would ensure that all stakeholders had plans in place to undertake the change as safely as possible.

A&E Services at Central Middlesex Hospital

The 24/7 A&E at Central Middlesex Hospital (CMH) had become unsustainable prior to the reconfiguration of hospital based services (Shaping a Healthier Future programme) being approved by the Joint Committee of Primary Care Trusts in February 2013.

In November 2011 an unplanned overnight closure of the A&E at CMH took place on clinical safety grounds. LNWHT (formerly NWLHT) was unable to provide safe staffing levels overnight and as a result it undertook an unplanned overnight closure to ensure the safety of the delivery of clinical services at CMH A&E. This closure of the overnight A&E services at CMH remained in place from November 2011 until the full closure of the A&E department in September 2014.

Following the unplanned night time closure in November 2011 the A&E daytime service at CMH was unable to accept certain types of higher level clinical conditions and higher acuity patients due to insufficient staffing levels and skill mix (including specialist nurses and consultants) to support safe standards of care for such conditions. As a result those patients that required higher level care such as children or those with stroke, major trauma, heart attack or those requiring acute surgical interventions were redirected to other A&E departments across North West London.

During the period from the unplanned overnight A&E closure at CMH in November 2011 and the planned closure in September 2014, patient activity levels had been incrementally reducing. Staff found it difficult to retain their skills and LNWHT were becoming more and more reliant on the use of locums. LNWHT was unable to recruit and retain an appropriately skilled workforce to deliver safe standards of care as it was not able to offer and support the type of clinical activity that staff would expect of an A&E department.

LNWHT had already advised that it was unlikely to be able to sustain safe staffing levels into the winter of 2014. This was highlighted to Brent Overview and Scrutiny Committee (OSC) at its meeting in August 2014 where David McVittie, the LNWHT chief executive, had advised Brent Councillors that independently of the reconfiguration of hospital based services (SaHF programme) CMH A&E would be unable to sustain safe staffing levels over the winter period of 2014. He also reported that the planned A&E closure would mean that, rather than undertake an unplanned closure as previously took place overnight at CMH A&E in November 2011, the programme provided the opportunity to enable a planned and safe closure of CMH A&E and transfer of activity within North West London.

The OSC was further advised and noted that the staff from CMH A&E would transfer to Northwick Park Hospital A&E department which would help support the move towards providing and ensuring that all patients have access to 24/7 high quality care, confirming the rationale for moving from nine major acute to five major acute hospitals across North West London. There was discussion at the OSC noting that the risks of keeping the A&E open into the winter of 2014 would likely outweigh the risk of closure as planned on 10 September 2014.

The new A&E department at Northwick Park Hospital opened in December 2014 which provides a better flow of patients through the department due to its co-location with other services, e.g. diagnostics. The hospital now employs more specialist A&E staff which has increased consultant cover in the A&E department thus improving clinical safety and care. Since the closure of CMH A&E, 58 new beds have been opened at Northwick Park Hospital, and 63 new modular beds are planned for 2015.

Urgent Care services at Central Middlesex Hospital

A 24/7 Urgent Care Centre (UCC) at CMH has been in place since April 2010. During the Spring and Summer of 2014 and in advance of the planned CMH A&E closure on 10 September 2014 an updated service specification, which required investment in additional staff, was put in place at the CMH UCC to ensure that it was able to operate as a standalone service ahead of the A&E closure. There was a three month period of 'testing' to check that the new and updated protocols were in place and working well and to address any issues in advance of the closure.

This included the development of a new pathway for patients with mental health crises to have direct access from the UCC at CMH into the mental health services at Park Royal provided by Central North West London Foundation Trust (CNWL), so that those patients that were medically fit did not need to be redirected to an A&E service to access the mental health services provided by CNWL. On-going training has been put in place with GPs and staff from across mental health and urgent care services to ensure that there is good awareness and utilisation of these pathways.

Assurance of the Central Middlesex Hospital and Hammersmith Hospital A&E Closures

The closure of CMH and HH A&E departments took place, as planned, on 10th September 2014 following an extensive and robust assurance process which included:

- **NHS England (NHSE) / Trust Development Authority (TDA) Stage One Assurance Report issued on 21 July 2014** – NHS England (NHSE) and Trust Development Authority (TDA) assurance of the Hammersmith & Fulham (H&F) CCG and Imperial College Healthcare Trust (ICHT) assurance processes and Brent CCG and North West London Hospital Trust (NWLHT) assurance processes, confirmed the right plans were in place and identified a number of areas for further work.

- **Hammersmith and Fulham CCG Governing Body meeting on 22 July 2014** - Agreed that the CCG was assured that changes to Emergency Unit services at Hammersmith Hospital can take place safely from 10 September 2014. Authorised the CCG Chair, Accountable Officer and the Chair of H&F CCG Quality and Safety Committee to advise the CCG's Governing Body if any major/significant unforeseen clinical or other issue arise after the 22 July 2014 such as, in their opinion, the risks of implementation outweigh at that time the risks of delay.

- **Brent CCG Governing Body meeting on 23 July 2014** - Agreed that the CCG was assured that changes to A&E services at Central Middlesex Hospital can take place safely from 10 September 2014. Authorised the CCG Chair, Accountable Officer and the Chair of Brent CCG Quality and Safety Committee to advise the CCG's Governing Body if any major/significant unforeseen clinical or other issue arise after the 23 July 2014 such as, in their opinion, the risks of implementation outweigh at that time the risks of delay.

- **Imperial Trust Board meeting on 30 July 2014** - confirmed Trust readiness for closure on 10 September 2014.

- **North West London Hospital Trust Board meeting on 30 July 2014** - confirmed Trust readiness for closure on 10 September 2014.

- **Shaping a Healthier Future Implementation Programme Board on 31 July 2014** - confirmed system readiness for closure on 10 September 2014.

- **NHS England / Trust Development Authority site visit of Imperial Trust sites on 5 August 2014** - NHSE and TDA assurance of the Hammersmith & Fulham CCG and Imperial Trust assurance processes, confirmed plans were progressing as expected and identified a number of areas for further work.

- **NHS England / Trust Development Authority site visit of NWLHT sites on 6 August 2014** - NHSE and TDA assurance of the Brent CCG and NWLHT assurance processes, confirmed plans were progressing as expected and identified a number of areas for further work.

- **Shaping a Healthier Future Clinical Board meeting on 21 August 2014** - confirmed readiness of Imperial Trust, NWLHT, Hammersmith UCC provider (Partnership for Health) and Central Middlesex UCC provider (Care UK) for the closure on 10 September 2014.

- **NHS England / Trust Development Authority Stage Two Assurance Report issued (in draft) on 21 August 2014** - NHSE and TDA assurance of the CCGs' and Trusts' assurance processes, confirmed plans were progressing as expected and identified outstanding areas of work before closure on 10 September 2014.

- **NHS England / Trust Development Authority Formal Sign Off of A&E Closures meeting on 26 August 2014** - discussed NHSE and TDA assurance of the closure on 10 September 2014.

- **Shaping a Healthier Future Implementation Programme Board on 4 September 2014** - All providers confirmed system readiness for closure on 10 September 2014.

Brent CCG is confident in its assurances that the A&E departments at CMH and HH closed safely and effectively on 10 September 2014 as planned. These changes are not, in Brent CCG's view, the cause of the recent pressures on A&E performance seen at LNWHT, across London and nationally. Rather, these changes have created greater operational resilience in the North West London urgent and emergency care system. This is supported by NWL demonstrating the best A&E performance metrics across London in quarter three of 2014/15, despite the increase in demand.

A&E Performance and Systems Resilience

In advance of and directly following the closures of the A&E departments at CMH and HH, daily Operational Executive meetings were established. These meetings included senior representatives from across North West London including Acute Hospitals, Urgent Care Centres, Mental Health Trusts, London Ambulance Service, CCGs, and social care. In addition, senior representatives from Acute Hospitals on the borders with North West London (ie: Royal Free in North Central London) attended.

The focus of these meetings was to identify areas of pressure across the system and to ensure that patients were conveyed to the most appropriate location to receive care as quickly as possible dependent upon their clinical condition. These meetings have supported and enabled a collaborative approach across North West London and wider to ensure patient care is optimised across the wider health economy. The Operations Executive continues to meet as they have been supported by all organisations to continue. This partnership approach to delivering high quality care to our population has been a successful outcome of the collaborative work that we have done to reconfigure hospital based service changes. This measure has enabled North West London to mitigate the increase in demand for A&E services experienced across London, and nationally. This is apparent in the performance in quarter 3 of 2014/15 which demonstrated that North West London had the best performance across London and confirms the underpinning principle of Shaping a Healthier Future; localising where appropriate and consolidating more specialist care where this is necessary. Northwick Park Hospital has coped better than it would have done if these changes had not been undertaken.

Brent CCG has invested in additional schemes to support improvements in A&E performance, and has jointly with London Northwest Healthcare NHS Trust developed a Brent and Harrow systems resilience plan which includes a number of initiatives to improve Brent's response to urgent care demand. An example of this is commissioning extra community rehabilitation beds for patients to be discharged sooner with the appropriate support.

Brent CCG is the coordinating commissioner for London Northwest Healthcare NHS Trust and as such undertakes all contract, clinical and governance meetings. The contract is implemented as agreed including local and national performance metrics (as per Monitor's National Guidance) such as delivery of Clinical Quality Incentive Schemes (CQUINS), implementation of marginal rate and other elements of the NHS National Standard Contract requirements.

As part of agreeing contract particulars, the CCG works with providers to agree reinvestment arising from Quality, Innovation, Productivity and Prevention (QIPP) gains, winter resilience funding and emergency marginal rate reductions. These are agreed in an open and transparent manner and resulted in more preventative services being commissioned including the Brent Short Term Assessment Rehabilitation and Reablement Service (STARRS), which is provided by LNWHT.

The CCG has further directed additional investment into extending the Integrated Care Programme (outlined below) and into community step down beds in order to further extend the opportunity to intervene, in this case to mobilise and discharge patients earlier, and to keep patients healthy within the community, to prevent hospital admissions and reduce length of stay within the hospital setting.

Our plans for the future also include more acute beds provision at Northwick Park Hospital, more investment in out of hours services and providing more joined up care closer to home.

BRENT CCG'S OUT OF HOSPITAL STRATEGY

Brent CCG has developed an Out of Hospital (OOH) Strategy to support the reconfiguration of hospital based services, the implementation of whole systems integrated care and the transformation of primary care services. The aim of this strategy is to realise the CCG's vision of 'providing the right care, in the right place, with the right professional and at the right time'.

To enable this we have invested substantial funding into a range of initiatives that support the delivery of our Out of Hospital Strategy. This is an on-going programme of service improvements which began in 2012. The initiatives below provide broad evidence of good progress in building NHS capacity in general practice and community services with a shifting emphasis on supporting people to stay healthy and manage long term conditions effectively in order to reduce the need for emergency care and unplanned admissions.

These initiatives comprise:

- Established **GP Access Hubs** in each of the five localities within Brent, which commenced as a pilot in November 2013. These hubs provide evening and weekend GP and nurse appointments until 9pm Mondays to Fridays, and 9am to 9pm on Saturdays. Following evaluation of the pilot, the service has recently been procured as a mainstream service to provide access to primary care services from 6pm to 9pm Mondays to Fridays and 9am to 3pm on Saturdays, Sundays and Bank Holidays. These hubs ensure that there is rapid access to primary care out of normal GP practice opening times. Brent CCG also commissions a Walk in Centre which is open from 8am to 8pm every day, 365 days a year. In addition, the CCG commissions an Urgent Care Centre which is open twenty four hours a day, seven days a week (24/7).

- Implemented consultant led **Community Ophthalmology Services** into community sites across Brent to improve patient experience of care, waiting times for referral to treatment and accessibility through provision in community settings (commenced October 2014).

- Extended our **Brent Short Term Assessment Rehabilitation and Reablement Service** to include a social worker to enable better links with the Local Authority. Brent STARRS has been recognised as an exemplar of integrated care for an ageing population who require support to remain at home during an acute exacerbation. STARRS further provides in reach to other acute hospitals with the aim of preventing hospital admissions as well as enabling early supported discharge and preventing possible re-admissions. STARRS has been in operation since 2011 and was expanded by the CCG in 2014.

- Introduced the **Integrated Care Programme (ICP)** through multidisciplinary meetings including the patient to develop personalised care plans, and recruited Health and Social Care Co-ordinators to interface with patients, the NHS and social care to improve patient care. The Integrated Care Programme commenced in 2012 and has been extended to a risk stratification approach to ensure all patients with long term conditions are identified and provided with care plans that are coordinated to ensure proactive care management for these patients.

- Launched **Brent Integrated Diabetes Services (BIDS)** in October 2014 to improve services for patients with type 2 diabetes. The new service offers multi-disciplinary diabetes care in primary and community settings and an extended patient education programme to help patients understand, manage and control their diabetes.

- Piloting a service for patients with **Sickle Cell** to improve care through an education and support programme for patients in March 2015.

- Extended our **Looked After Children and Child and Adolescent Mental Health Services (CAMHS)** to improve service provision for this specific group of vulnerable children with complex mental health needs in August 2014.

- Established **Primary Care Dementia Nurses** for each locality within Brent, which has been in place since May 2014, to increase capacity for early diagnosis and provide early intervention as well as an effective interface between primary care and secondary care services for patients with dementia. In addition, the CCG and Brent Council jointly commission a Dementia Café for patients and carers with dementia.

As a result of these initiatives being implemented we have evaluated the impact of each scheme as set out below:

GP Access Hubs
Have provided more than 70,000 additional GP and nurse appointments in primary care, providing the opportunity to intervene earlier and reduce reliance on walk in, urgent and emergency care services. This service is being extended to include Sundays and Bank Holidays which will provide out of hours access in more locations in the borough.

Community Ophthalmology Service
It is too soon to provide robust analysis in this short timeframe (service commenced late October 2014). However, early analysis has shown an increase in referrals into the new service and feedback from patients and referring clinicians has been positive.

STARRS
This service has demonstrated year on year improvements in preventing admissions. To date, the service is on track to prevent 2,796 admissions in 2014-15 against a target of 2,300. In the nine month period from April to December 2014 2,206 admissions were avoided through intervention by the STARRS team.

Integrated Care Programme
Since the ICP started in 2012, in excess of 8,500 care plans have been completed to date. 142 multi-disciplinary group meetings (MDGs) have been held and 477 patients discussed at these meetings. Five Health and Social Care Co-ordinators have been recruited to follow up and ensure actions in care plans are implemented and to help people navigate the health and social care system. A bespoke training programme has been put in place by Professor David Sines. Evaluation of over 600 patient surveys has demonstrated that the service has enabled 72% of people with a care plan to be more confident to manage their health and 75% of care planned patients said that their family or carer were involved in decisions about their health as much as they wanted them to be.

Through monitoring of non-elective admissions that relate to patients with specific long-term conditions, there has been a reduction of 398 non-elective (emergency) admissions according to the latest Month 8 analysis. This compares long-term condition related

admissions between 2013/14 with 2014/15, and demonstrates that ICP has made an impact in reducing overall admissions in this cohort of people.

Brent Integrated Diabetes Service (BIDS)
It is too soon to provide robust analysis in this short timeframe (service commenced October 2014). The impact expected is a reduction in the number of emergency admissions to hospital for diabetic patients, as well as greater attendance by patients at the Diabetes Education and Self-Management for On-going and Newly Diagnosed (DESMOND) programme, a higher proportion of insulin initiations in the community setting with an improvement in patient satisfaction.

Sickle Cell
This service is due to commence in March 2015 and is being provided by the Sickle Cell Society to provide pre-admission and post admission intervention and support. The anticipated impact is a reduction in A&E attendances and admissions due to early intervention and support, leading to better clinical outcomes for patients.

Looked After Children and Child and Adolescent Mental Health Service (CAMHS)
Following Brent Council's decision on 9 December 2013 to commission a reduced mental health service for Looked After Children, arrangements were made to safely transfer the care of 51 Looked After Children, and 86 children with developmental progress difficulties to other services. Brent CCG invested an additional £220k (recurrent full year effect) into the existing Central North West London Foundation NHS Trust (CNWL) CAMHS service to provide dedicated resources for Looked After Children, and children with developmental progress difficulties. In addition to changes in the scope of CCG commissioned CAMHS there has also been a steady increase in the numbers of children being identified with mental health problems. If not treated early, these problems can become increasingly complex, entrenched and detrimental to the life of the child. In response to this, Brent CCG has invested a further £66k with Brent Centre for Young People's Centre to increase capacity and reduce waiting times as a result of increased referrals and the complexity of cases, so that children are seen more quickly and have access to treatment at an earlier stage of their illness.

Brent CCG, in partnership with the North West London CCGs Collaboration, has recognised the need to improve out-of-hours CAMHS provision and has agreed to invest an additional £140k as part of a £1.1m pilot which is aimed at improving the urgent care response to children and young people with a mental health crisis. The pilot will be undertaken during a comprehensive review of CAMHS in 2015/16 to inform the future service developments required.

Dementia
Brent CCG invested £397k in specialist dementia services made up of five specialist mental health nurses to support carers and patients after a diagnosis of dementia. The nursing team works as a bridge for patients between primary care services and the specialist Memory Clinic dementia service. All patients now receive support and advice following specialist diagnosis at the memory clinic, thus improving the quality of life for patients and their carers. From April to December 2014, the new Primary Care Dementia Nursing Service worked with 238 newly diagnosed patients and their carers.

Future plans supporting the delivery of Brent CCG's Out of Hospital strategy

- Prime Minister's Challenge Fund (PMCF) investment has resulted in 59 of our 67 GP practices now offering telephone consultations as an alternative to face-to-face appointments, 55 practices offering online appointment bookings, and 55 practices offering longer appointments to those that need them. Further developments are being implemented to provide improved services to meet patients' needs and expectations for access to continuity of care and responsive care. These developments include: a centralized infrastructure to support high quality population care seven days a week for complex patients; increase the quality and productivity of primary care against local and national benchmarks through the use of innovative technology such as videoconferencing and email consultations; to support multi-disciplinary and new models of care that fit around patients' needs; to improve patient experience, outcomes and satisfaction; and to develop a single point of access for easier and more convenient appointments bookings for patients.

- On 2 March 2015 a consultant led community cardiology service will be launched from community sites across Brent to improve access in the community setting and to reduce waiting times.

- We are currently developing a service model for patients with respiratory conditions that will provide a bridge between primary and community services and improve long term condition management in the community for this group of patients.

- We are in the process of commissioning an Early Supported Discharge for Stroke Service to provide specialist care and rehabilitation for stroke patients in their homes, and by providing intensive packages of support to increase independent living. We anticipate this service will commence during 2015/16.

- We are developing more Consultant Led Community Services to include Gynaecology and Musculo-skeletal services into community sites across Brent to improve access in the community setting, reduce waiting times and improve patient experience of care. Evaluation of pilot schemes that have tested these models have shown good evidence of improved clinical outcomes and patient satisfaction with improved speed of access to and quality of these services.

- The implementation of primary care monitoring of patients on Disease Modifying Anti-rheumatic Drugs (DMARD) under a shared care agreement with secondary care to improve access and deliver more convenient care closer to home for patients.

- The provision of anti-coagulation monitoring in primary care is being trialed to improve access and deliver more convenient care closer to home for patients.

Joint working

Brent CCG is working with various stakeholders including Brent Council to deliver its strategic objectives including the Out of Hospital Strategy. An example of our joint working with Brent Council is though our jointly chaired Integration Board, which is responsible for overseeing the delivery of our Better Care Fund plan in Brent. The plan has been developed in partnership with the Council as well as a range of providers, lay and voluntary sector partners. The Brent Better Care Fund plan is comprised of four schemes to improve the health and wellbeing of Brent residents with a specific focus on reducing reliance on acute and institutional care that is a central policy directive associated with the Better Care Fund.

Our engagement work with patients and the public has recently been independently reviewed by a recognised national expert from the King's Fund. This has led to 12 recommendations which are currently being implemented through an Implementation Transition Group which includes a number of patient representatives from our previous structures. We are in the process of developing our communications strategy in response to the independent review recommendations which we anticipate will provide further opportunity to engage more meaningfully with patients and the public and to ensure we commission services in a manner that patients and the public tell us that they want.

The CCG regularly speaks at local council ward meetings to update on services being developed and to promote proactive and preventative health care as alternatives to A&E.

CONCLUSION

As stated above, Brent CCG believes the reconfiguration of A&E departments in NWL has been the right thing to do for clinical safety and delivering better patient outcomes 24/7 across NWL.

We do not believe that the closures are the cause of increased pressure on Northwick Park or other A&E units in NWL and across NWL clinical commissioning groups and provider trusts are working hard to manage the rising demands on A&E which are being seen across London and the country as a whole. These changes have created greater operational resilience in the North West London urgent and emergency care system. This is supported by NWL demonstrating the best A&E performance metrics across London in quarter three of 2014/15, despite the increase in demand. Accepting that performance against national targets is not as high as we would like to see it; without the co-ordinated work across NWL to make A&E services safer and more resilient we do not believe performance would be as good as it is now.

To support the work of shifting more services out of hospital we have made substantial progress in developing capacity and capability in general practice and community services; and continuing this remains a top priority for the CCG.

I hope this is helpful information to aid your inquiry into what is a complex issue.

Yours sincerely

Etheldreda Kong

Dr Ethie Kong
Chair
Brent Clinical Commissioning Group

NHS
Central London
Clinical Commissioning Group

15 Marylebone Road
London NW1 5JD

By Email

Mr Mansifield QC
c/o Peter Smith
Room 39
Hammersmith Town Hall
London
W6 9JU

23 February 2015

Dear Mr Mansfield QC,

NHS Central London CCG submission

Thank you for giving us the opportunity to formally submit evidence to your review.

As the Chair of Central London NHS Central London Clinical Commissioning Group (CCG), I am committed to commissioning and delivering a service that gives patients and our clinical colleagues the confidence that we can balance excellence in clinical quality while fulfilling our financial duties.

The case for change remains as strong as the original North West London Joint Committee of Primary Care Trusts (JCPCT) proposal, which was subsequently scrutinised by the Independent Reconfiguration Panel and a High Court case and endorsed by the Secretary of State for Health. Similar to the successful London-wide stroke and trauma centralisation, we believe that by investing in centralised major acute hospitals we can save lives, whilst local hospitals can specialise proactively in the needs of the local population. At the same time, we continue to invest in out of hospital care so that we can also seek to prevent avoidable visits to acute care.

Acute provision
The Accident and Emergency system nationally has seen unprecedented demand over winter. Between October-December 2014, North West London remained the highest performing area in London with increased staffing at our A&Es.

Our doctors and nurses have been working incredibly hard, under difficult circumstances, to treat a significant extra number of patients within the key four-hour timeframe. Winter is always a tough time for us in the NHS, and in particular A&E, but we need to try and move towards a more sustainable future for our health services providing better and accessible care for all patients. When you need treatment for a life-threatening condition, we now have increased consultant cover in A&E with a further 6 A&E consultants across Imperial Healthcare Trust's A&E sites.

We are also planning to develop the St Mary's site and build new hospitals at the Charing Cross site and outside our area, at Ealing. St Mary's will be a major hospital and Charing Cross will be a local hospital, which will be specifically tailored to local needs as well as providing general care. All emergency and urgent care services will fit with the new models of care to be announced by Sir Bruce Keogh and Keith Willett. We will also be creating 27 primary care hubs across NW London, including one within St Mary's Hospital ensuring more integrated, more joined up care.

Urgent and Emergency Care
Urgent Care Centres play a vital role in providing care when you really need it but when your condition isn't life-threatening. In North West London, we now have nine 24/7 Urgent Care Centres including, in the Central London CCG area, at St Mary's, Chelsea and Westminster, Hammersmith and Charing Cross hospitals.

Our Out of Hospital Strategy has rapid response to urgent healthcare needs as one of its key priority areas. The CCG will continue to work to ensure that patients requiring urgent or emergency care are treated in the timeframe and setting appropriate for their needs. We will continue to work to reduce unnecessary Urgent Care Centre and A&E attendances and avoidable hospital admissions by fully utilising alternative services in the community.

During 2014/15 we have enabled the NHS 111 service to book GP practice appointments where needed, including evenings and weekends. We are increasing patient education through targeted activities to raise awareness of ways of accessing urgent care.

Primary care transformation
The CCGs in North West London are working together to deliver transformed, sustainable primary care. At the heart of this work is the intention to improve the quality of general practice and reduce the known variation in quality, while ensuring a thriving and successful primary care service which best meets the needs of our local population.

We also know that GPs are already extremely busy but that people still struggle to get an appointment at a convenient time for them. This is why we now have four surgeries open at the weekends – either for residents to walk-in or book the same day appointments – even if they are not registered at that practice. The CCG has also had a wide campaign of publicising its weekend opening practices including posters in bus stops, leaflet drops and also advertising in Health and Social Care buildings.

All the GP practices in each CCG are also now working together to offer a wider range of services than they could do if they worked on their own. To do this, we are all investing in developing hubs where a number of services are provided in one building. In Central London, our long-term plan is to develop three hubs or health and wellbeing centres in Lisson Grove in the north of the borough; and South Westminster Centre for Health. We also want to develop a hub in the centre of the borough and we are actively looking at locations where this could happen.

Whole systems integration and the Better Care Fund
Together with Hammersmith & Fulham, and West London CCGs, we will be introducing the Community Independence Service (CIS) to deliver more rapid and responsive out of hospital care for people with acute needs and provided by health and social care teams working together in a co-ordinated way.

The tri-borough CCGs have commissioned a single provider who will manage the new financial investment of £1.7m (into health providers) over 2015/16 to ensure appropriate

staffing levels for expected increase in referrals and deliver to the new specification across all boroughs.

This programme represents a new way of working with Local Authority colleagues where solutions for patients are identified and implemented across organisational boundaries seamlessly, with the patient and their family at the heart of decision making. Some of the specific services are highlighted below:

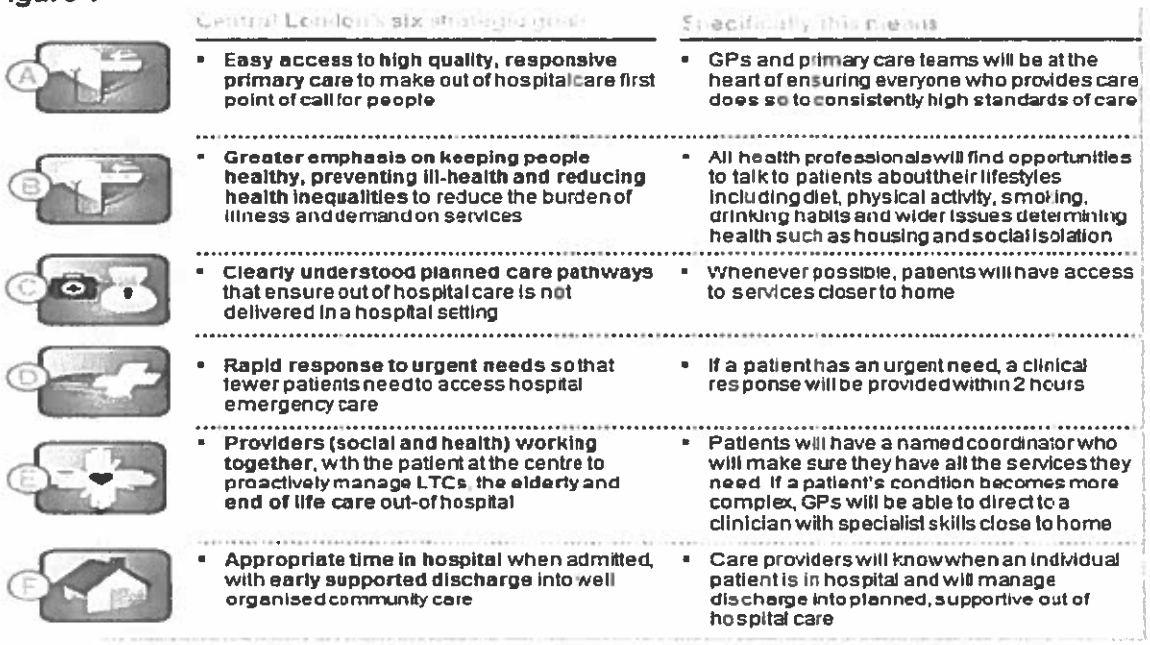
Rapid Response	A multi-professional (medical, nursing and social care) rapid response service, operating 8am to 8pm; 7 days a week), that can provide face to face assessment at home within 2 hours of referral, support up to 5 days following referral and provide referrals to ongoing support.
In Reach	An integrated case finding and in reach service, operating 8am to 8pm; 7 days a week, with a presence in A&E. The In reach service links to the wider urgent care system, community beds, care homes urgent care and out of hours services (including NHS 111). Provides proportionate assessment and referrals to ongoing support.
Non- bedded Integrated care and rehabilitation	A delivery team, working as part of an integrated CIS (medical and social care), operating 8am to 8pm; 7 days a week, that provides time-bound rehabilitation (therapies) for referrals via the Single Point of Referral (SPoR) service by treating people with non-complex conditions in a community setting with the aim of goal attainment. Responds to all referrals within 24 hours and commencement of care within 72 hours.
Reablement	A delivery team, working as part of a single integrated CIS (medical and social care), that provides reablement services for referrals via the SPoR for people for up to 12 weeks (as required). Responds to all referrals within 24 hours and commencement of care within 72 hours. Includes specialist falls input within CIS timeframe (6-12 weeks over time). Where longer term care is required, includes links to additional reablement services including assistive technology provision such as telecare.

The CCG is also working with partners and stakeholders across the local Health and Social Care economy to co-design the future of care. This means that people will receive:

- Timely care that is organised to meet their needs
- The services they require will be coordinated across sectors as a coherent package, with a focus on helping them to keep healthy, get better, prevent relapse and get on with their normal lives.

This promise translates into six goals as outlined in figure 1, which determine how we will change care in the Central London CCG area.

Figure 1



Central London's six strategic goals	Specifically, this means
• **Easy access to high quality, responsive primary care** to make out of hospital care first point of call for people	• GPs and primary care teams will be at the heart of ensuring everyone who provides care does so to consistently high standards of care
• **Greater emphasis on keeping people healthy, preventing ill-health and reducing health inequalities** to reduce the burden of illness and demand on services	• All health professionals will find opportunities to talk to patients about their lifestyles including diet, physical activity, smoking, drinking habits and wider issues determining health such as housing and social isolation
• **Clearly understood planned care pathways** that ensure out of hospital care is not delivered in a hospital setting	• Whenever possible, patients will have access to services closer to home
• **Rapid response to urgent needs** so that fewer patients need to access hospital emergency care	• If a patient has an urgent need, a clinical response will be provided within 2 hours
• **Providers (social and health) working together**, with the patient at the centre to proactively manage LTCs, the elderly and end of life care out-of hospital	• Patients will have a named coordinator who will make sure they have all the services they need. If a patient's condition becomes more complex, GPs will be able to direct to a clinician with specialist skills close to home
• **Appropriate time in hospital** when admitted, with **early supported discharge** into well organised community care	• Care providers will know when an individual patient is in hospital and will manage discharge into planned, supportive out of hospital care

The group has co-designed a new model of care which includes a significant amount of additional clinical resource supporting patients earlier on in their lives with the aim of keeping them well for longer. The CCG and partners are currently reviewing a service specification and draft business case to enable this change. The CCG intends to start to deliver this change during 2015/16. This programme is underpinned by extensive local engagement including patients and colleagues from the voluntary sector. Events have been held to design the model of care as well as simulation events designed to test the solutions identified.

Out of Hospital Care

Central London, West London, Hammersmith & Fulham, Hounslow and Ealing (CWHHE) CCGs have decided to work together to enable transformation within primary care across the five CCGs. The five CWHHE CCGs also work as part of the 8 CCGs of NWL, particularly in relation to primary care, but this programme of work is specific to the CWHHE CCGs alone.

Each CCG has an Out of Hospital strategy that describes keeping the patient at the centre of their own care, with the GP as a key provider and coordinator of services. In addition, key strategic priorities for the CCGs are to improve quality, reduce variation within primary care and ensure equity of access to services, including new out of hospital services to be delivered through GP practices.

Patient and Public involvement

Finally, we put patients at the heart of everything we do. Wherever possible we get lay members and the public involved in helping to develop our work. Not only does this lead to better thought-through policies, but also enables us to present them in plain English. For our commissioning intentions, for example, we delivered a comprehensive survey and also a series of focus groups with residents. The most recent one was in November 2014 where we discussed the specifics of the CCGs whole system integrated care programme.

Likewise, we value the input received from the Health and Wellbeing Board as well as the always constructive dialogue we have from Westminster City Council. In addition to the joint work that we are undertaking as part of the whole systems integration work, we are constantly encouraged by the support and challenge, whether this is on public health issues, out of hospital or acute services.

In conclusion, we feel that this provides a comprehensive picture across the different transformation programmes and what we are doing to continue to improve healthcare for our patients in Central London.

Yours faithfully

Dr Ruth O'Hare
MA, MB, BChir, MRCP
Chair Central London Clinical Commissioning Group
GP Principal Connaught Square Practice

NHS
Hounslow
Clinical Commissioning Group

Sovereign Court
15-21 Staines Road
Hounslow, TW3 3HR

By Email

Mr Mansifield QC
c/o Peter Smith
Room 39
Hammersmith Town Hall
London
W6 9JU

23rd February 2015

Dear Mr Mansfield QC

NHS Hounslow Clinical Commissioning Group submission

I am writing to you and your colleagues on your inquiry on behalf of NHS Hounslow Clinical Commissioning Group (CCG). I will set out in this letter evidence which I hope will help the inquiry to understand why Hounslow CCG, which I chair, continues to support the transformation of the healthcare landscape in North West London as detailed in the Shaping a Healthier Future programme (SaHF). We are convinced that SaHF, in conjunction with the CCG's Out of Hospital strategy, will ensure the population of Hounslow and the patients of our member GP practices receive the most appropriate healthcare in the most appropriate setting.

Some background information about Hounslow's population
As of the beginning of January 2015 Hounslow's 54 GP practices have a *registered* patient population of 299,928. It is one of the most rapidly growing boroughs in London with growth of 12% predicted by 2020. Hounslow's population is also expected to change its age profile, with the over-65 age group expected to grow by 18% in the same time frame. Hounslow CCG has the same geographical boundaries as its predecessor Primary Care Trust (PCT).

Life expectancy at birth for men and women is 79.5 and 83.3 years respectively. However, healthy life expectancy at birth for men is 60.8 years, significantly worse than England as a whole, and before the age of retirement. For women, 63.2 years of healthy life is expected at birth. Increasing healthy life expectancy (in relation to life expectancy) will help improve wellbeing in the borough and decrease health and social care costs. The main causes of early death in Hounslow are cancer, heart disease and stroke. Around 1,674 premature deaths in people aged under 75 years occurred in the borough between 2010 and 2012. In many cases, several years of health and social care input preceded the early death.

The main preventable causes underlying these premature deaths are smoking (currently 30,000 smokers in the borough), inactivity and obesity (an estimated 63% of adults in Hounslow are overweight, 29% are 'inactive' and less than 10% use outdoor spaces for exercise or health), and alcohol misuse (Hounslow is significantly worse than England as a whole for alcohol-related hospital admissions). There are currently around 14,000 people

with diabetes in the borough, and an estimated 5,000 undiagnosed cases of diabetes, of which a high proportion will be closely linked to obesity. Without major changes, preventable ill-health and these early deaths will continue and may even increase in the borough. (London Borough Hounslow Public Health Commissioning Strategy 2014-18)

Hounslow is one of the most diverse populations in London. In the 2011 census the three most common ethnicities were white British, Indian and Pakistani. Hounslow has a number of recently emerging populations including Afghan, Algerian, Bulgarian, Burmese, Romanian and Sri Lankan communities and very recently the Nepalese population has grown significantly.

More than half of Hounslow's population lives within the lower half of the national scale of deprivation; and approximately 1800 of the local population live in an area which is ranked among the 10% most deprived in England, while about 6000 live in areas in Hounslow ranked in the 10% most deprived in London. Deprivation is not the same as poverty. Data from HM Revenue and Customs indicates that 28% of children in Hounslow live in poverty, higher than the national average of 21%, but lower than the overall rate for London of 31%. The proportion of children living in poverty ranges across Hounslow's wards, from 12% (Hounslow South) to 40% (Isleworth). Both poverty and deprivation have significant impacts on the health and wellbeing of individuals.

Detailed information on the demographics and health needs of Hounslow's population is contained in the Joint Strategic Needs Assessment (JSNA) produced by the Public Health Department of the London Borough of Hounslow. The JSNA is used by Hounslow CCG and the London Borough of Hounslow to develop our joint Commissioning Intentions.

Hounslow CCG consulted widely on SaHF

The CCG has supported SaHF since its inception. The CCG and its predecessor PCT firmly believe that SaHF will improve the health of the Hounslow population. The CCG included the planned transformation in its Communication and Engagement Strategy in late 2011 and signed the Memorandum of Understanding in August 2012 with the seven other shadow North West London CCGs.

The London Borough of Hounslow Health Scrutiny Panel was updated on the planned North West London Acute Transformation on a number of occasions from 2011 onwards with March 2012 being the first panel meeting scrutinising the Shaping a Healthier Future strategy.

The CCG has undertaken significant, on-going engagement and consultation on SaHF both with its GP members and with a range of patients, carers and members of the public. The full programme of engagement prior to decision making is detailed in appendix B of the SaHF Decision Making Business Case. More recently engagement has been undertaken in a range of ways including at the CCG's AGM, joint Commissioning Intentions consultation and Whole Systems Steering Group.

Hounslow CCG has a two-pronged approach to improving services for patients.

1. the implementation of our Out of Hospital Strategy
2. the implementation of acute service reconfiguration.

We firmly believe one cannot be delivered without the other. Our Out of Hospital strategy has evolved through our Whole Systems Integrated Care, Better Care Fund and Prime Minister's Challenge Fund programmes.

Our achievements so far and our plans for the future

In June 2011 we implemented the Integrated Community Response Service (ICRS) - a team of GPs, nurses, therapists, a mental health nurse, a handyman and a social worker available from 7am to 7pm seven days a week. ICRS provides patients over the age of 18 with help within two hours of the service being called. The team provides rapid assessment and intervention and aims to prevent people going into hospital or a care home when they could be looked after in their own home. The team also provides support at home to allow people to return home from hospital more quickly. In July 2014 we further enhanced this service by including an additional care pathway from London Ambulance Service directly to ICRS.

London Borough of Hounslow social workers and GPs are working together in localities. Two pathfinder localities (Feltham and Great West Road) are piloting this initiative with the existing locality multi-disciplinary groups. From April 2015 this will be rolled out across all five localities. Our multi-disciplinary teams work with the voluntary, community and independent sector to support highest risk patients to ensure they can access all the services they need, self-manage their conditions and proactively ask for help, so they remain healthy, independent and well.

GPs are undertaking clinical sessions in care homes at weekends to help reduce admissions to hospitals from care homes. At least one GP surgery per locality has been open at weekends and bank holidays for over a year. Further innovations facilitated through the Prime Minister's Challenge Fund include 8am – 8pm opening in each locality and supporting patients to interact with GPs by expanding the use of the internet. NHS England has reported 98% of Hounslow practices are offering the facility to make appointments and order repeat prescriptions online.

The London Borough of Hounslow and the CCG have jointly procured an integrated recovery-focused Personal Care Framework to provide people with effective and appropriate high quality health and social personal care at home as an alternative to traditional homecare or people having to go unnecessarily into nursing or residential care.

Additional social worker capacity, including a presence in our Emergency Department in West Middlesex University Hospital, is an integral part of Better Care Fund plans to support the acute sector. Additional hospital social worker capacity will ensure that more Social Care assessments are completed within 48 hours. This will significantly reduce the number of delayed transfers of care. We have remodelled the hospital service to extend social care to 7 days per week, and ensure that weekend discharges are enabled and that homecare packages under the new Personal Care Framework are able to be set outside of normal office hours. This has been initially resourced through Winter Resilience 14/15 pump priming funding since November 2014, and will be funded through the Better Care Fund from April 2015.

Hounslow CCG has agreed to commission an Out of Hospital Services (OOHS) portfolio, with standardised specifications and prices, to replace the previous Local Enhanced Services (LES). This will ensure that for the first time all patients are able to access the same range of services across Hounslow.

For Hounslow CCG, the total investment of £4.4m represents an increase of £2.3m on the 2013/14 LES budget. OOHS are being commissioned at a GP locality (network) level, with these new GP provider organisations taking responsibility for ensuring that all patients within the locality are able to access all the services. Chiswick Locality is the first in Hounslow which has gone live with the eight OOH services including anticoagulation (levels 1 & 2) and case finding, care planning & care monitoring.

When fully implemented, the full range of services will include: diabetes (level 1, level 2 and high risk); anticoagulation (level 1 & 2); care planning; wound care (simple and complex); near patient testing; phlebotomy; spirometry; Co-ordinate My Care (end of life care planning); electrocardiogram tests; homeless services and mental health services (transfer of care and managing complex common mental health issue); and ring pessary.

We have commissioned a Community Heart Failure Service from West Middlesex Hospital to provide treatment for patients registered with a Hounslow GP who have a confirmed diagnosis of heart failure. The aim of the service is to increase access to specialist heart failure team advice for primary care colleagues and to support patients who have recently been discharged from secondary care or experienced heart failure. The Consultant-led service is delivered by two specialist heart failure nurses who are supported by West Middlesex Hospital clinicians.

We have also recently commissioned a new Community Diabetes Intermediate Care Service with three distinct elements of service delivery that will go live in May 2015. The service includes care for intermediate patients with diabetes, foot protection, and patient education. The service will provide patients in Hounslow with a robust, safe and reliable community based diabetes care that meets their needs and improves their health outcomes.

A new Ambulatory Emergency Care Service using the patient's GP record is available at West Middlesex Hospital for people who need urgent hospital care but don't require an urgent care centre or A&E attendance. Patients will be assessed, diagnosed and treated on the same day where possible with follow up outpatient appointments where necessary. The service can refer patients into the weekend opening service if appropriate.

In partnership with the London Borough of Hounslow we have plans to continue to invest in Out Of Hospital care with a total investment of £16.9m in 15/16 under the Better Care Fund. This will be in programmes, such as:

- Helping people to self-manage and providing care navigation
- Investing in reablement and rehabilitation through an Integrated Community Recovery model
- Investing in locality based social work
- Providing universal Information, advice and signposting
- Integrating NHS and social care systems around the NHS Number and through a single point of access across health and social care
- Integrating dementia services
- Seven day working in localities for GP services and hospital social work teams supporting community provision
- Investing in care homes, both in relation to GP cover and support and quality monitoring.
- Rolling out Care Plans for over 75s through primary care and co-ordinated care

We are redesigning our rehabilitation and reablement service model and pathway to provide, alongside the Integrated Community Response Service, a Community Recovery Service: a combination of reablement and community rehabilitation, which will work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and to self-manage their health conditions and medication. The service will introduce patients to assistive technologies such as Tele-care and Tele-health. This further integrates social and community care.

In conclusion
I would like to confirm that Hounslow CCG remains fully committed to the SaHF programme. By delivering on our Out of Hospital programmes we are providing the appropriate settings for patient care that will deliver the positive outcomes envisaged under SaHF.

The proposals have been fully scrutinised by local clinicians from across the health system, an Independent Review Panel, the High Court and the Secretary of State. The CCG continues to believe the SaHF programme is absolutely necessary to secure a sustainable and safe health service in North West London in the long term.

Yours sincerely

Nicola Burbidge
Chair
NHS Hounslow Clinical Commissioning Group

Healthy Future

NHS
Hammersmith and Fulham
Clinical Commissioning Group

NHS Hammersmith and Fulham CCG
15 Marylebone Road
London
NW1 5JD
T: 020 7150 8000
www.hammersmithfulhamccg.nhs.uk

By Email

Mr Mansifield QC
c/o Peter Smith
Room 39
Hammersmith Town Hall
London
W6 9JU

23rd February 2015

Dear Mr Mansfield QC,

Thank you for providing the opportunity for Hammersmith & Fulham Clinical Commissioning Group (CCG) to respond to your review. Shaping a Healthier Future (SaHF) forms a central part of our strategy, both in terms of the reconfiguration of existing specialist provision at acute hospitals and the development of more personalised, integrated services closer to residents' homes. We commission for a comparatively small population (just over 180,000) in a very small geographical area (6.3 sq miles), so we are very conscious of the need to accept that some specialist services are better provided outside of the borough in order to secure the best possible quality standards and improve patient outcomes. Moving any health service outside the borough is controversial, but this needs to be considered within a broader understanding of how we commission services to meet our population's current and future needs.

In the 'Call for Evidence' document, published on 16 December 2014, you gave us the opportunity to submit written evidence that may assist you in your consideration of the impact of recent changes on patient care in the area arising from the SaHF programme. This letter represents our response to you on this matter. In summary, we are confident that the investment we have made and are planning to make in transforming our local health system will not only support the delivery of SaHF, but will significantly improve the quality of care and the lives of local residents. Our response is structured around the following areas:

1. The local context – which is the background to understanding the decisions we have made as commissioners
2. Our investment in out of hospital services – this is integral to our strategy, and complements the changes we have made in acute services
3. The specific changes to hospital services as part of SaHF – this is where we provide the specific evidence relating to the recent changes to the Hammersmith Hospital Emergency Department (ED)

We conclude with a summary of the key points of the evidence we have provided in these areas.

I have met with two of your colleagues, Sean Boyle and Roger Steer to discuss the subject of your review and would welcome the opportunity to discuss this further with the inquiry in due course.

1. Local context

Our starting point as the statutory commissioner of health services for residents and the registered population of Hammersmith & Fulham is to develop an understanding of the needs of our population. We do this through the routine collection and analysis of demographic data, through joint work with the London Borough of Hammersmith and Fulham (LBHF) on the Joint Strategic Needs Assessment, through our patient and public engagement team and programmes through our GP members and their day to day experience of treating Hammersmith and Fulham patients and of the residents who sit as lay members on our governing body. We consider that we have a good understanding of the needs of our population.

In common with other inner city areas in the UK (and especially in London), the borough is relatively young, diverse and with areas of significant deprivation. This diversity is reflected in the manner in which they access health services, meaning a more flexible and innovative approach will allow us to meet the needs of all of our residents. For example we know that a small group, approximately 20%, of our population use more than 70% of our health and social care resources. Many of this group are older people with a complex range of conditions, who need personalised care, coordinated by a health and social care team either very close to or in their own homes. At the same time, we are conscious that a significant proportion of our residents are younger people, who value convenient access to primary care for relatively straightforward conditions.

The challenge for us as a commissioner is to ensure that we meet all of these needs, and those of the rest of our residents, in a manner that is proportionate, equitable, provides safe and high quality services and is sustainable in the long term for the taxpayer. We have pioneered innovative ways of 'segmenting' our population – our work in this area is cited as best practice nationally and is referenced in the London Health Commission report (http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf). We will continue to work with our partners in health and social care to use this data to further develop integrated care models that work for different population groups.

2. Investment in Out of Hospital services

Primary Care

We know that more than 90% of contacts with the health service take place in the community, involving general practice, pharmacy and community services. We also recognise that a successful primary care system is key to the success of the SaHF programme. We invested £4.45m in primary care during 13/14 and 14/15. Much of this investment has been channelled through the five GP practice networks, increasing collaboration, helping to share best practice and moving toward greater consistency of care.

We are expanding access to primary care, for example through investing just under £700k in providing 7 day access to primary care in five different practices across the borough. ,These are now available for booked and walk-in appointments from 9am until 4pm on Saturday and Sunday, irrespective of whether the patient is registered at one of those practices. Much of this work is being developed in conjunction with the current provider of GP out of hospital services, the GP Federation.

As well as expanding access, we are also expanding the breadth of services available through primary care. We will invest £2.5 million in 15/16 to provide a single contract covering all of our population, meaning residents will benefit from consistent management of conditions including diabetes, 24 hour blood pressure monitoring and complex wound management coordinated across the borough.).

In addition, all Hammersmith and Fulham GPs are now using the same software, called SystmOne, which allows, with consent, personal information to be shared across all 30 practices to improve patient care.

Access to clinical specialists
Improving access to specialist opinion helps to ensure that residents with a long-term condition or a potentially recurrent health issue can receive the right advice from the outset. This is best achieved through GPs and hospital clinicians working together to share expertise and agree a treatment plan with the patient. For example, during 2014/15:

- We have procured a community gynaecology service, staffed by GPs with a specialist interest and hospital doctors, which will be at full capacity by 1st April. This will mean more flexible appointments including evenings and weekends, reduced waiting times and an increased range of specialist services for local women closer to their homes.
- We have begun to develop a cardio-respiratory community service and will be procuring this during 2015/16. Whilst we already have a community respiratory service we do not have a community cardiology service. This results in high hospital attendances and admissions for heart failure. Combining these services within a single community service will allow us to improve treatment for overlapping health conditions, improving waiting times and access, and preventing repeat diagnostic tests.
- At Parkview Centre for Health and Wellbeing, we have created a brand new, state of the art health and wellbeing centre. It contains four GP practices and a wide range of community and social care services, including a Connecting Care for Children (CCfC) pilot. Through this initiative paediatric consultants and GPs run joint clinics to provide specialist advice to families in an area where we know there is significantly higher demand for children's services.

These services are examples of specialist community services which reduce the need for local residents to travel to hospitals. These services also mean we can intervene earlier when people are slightly unwell, reducing the need for unplanned stays in hospital.

Mental Health Services Closer to Home
The same principle applies to mental health, where investment in wellbeing and early intervention can significantly reduce the need for specialist intervention at a later stage. During 2014/15, we have:

- Invested in four Primary Care Mental Health Workers that support GP practices to manage more complex mental health patients. We have also increased access to the psychological services (IAPT) for patients with common mental illness and are on-track to achieve the national target in 14/15, with over 50% of people who receive IAPT moving to measurable recovery. Both of these achievements are in excess of national targets.
- Worked with the National Clinical Director for Dementia, Professor Alistair Burns, to design a primary-care led memory service. We will procure this service during

2015/16. This will facilitate earlier diagnosis, bring specialist services closer to residents' homes and reduce waiting times.

- Identified the need for a specialist perinatal mental health service as a priority for those women who experience severe mental illness during and after pregnancy. During 2015/16 we will commission a service to expand specialist support to those with mild to moderate perinatal mental illness. The specification for this new service is being co-designed with social care, health visitors, obstetricians, children's centres and service users, both mothers and fathers.
- Invested in our out of hour's service for Children and Adolescent Mental Health (CAMHS). We are also reviewing the CAMHS service that we provide to ensure that our most vulnerable young-people consistently receive the right care, in the right setting at the right time.

Providing integrated services for people with complex needs

Providing joined-up care for our older residents with complex and long term health conditions is a significant focus for the CCG. Too many of our residents and their carers are faced with a fragmented, confusing system which often results in long stays in an acute hospital, poor experiences of care and represents poor value for money for the taxpayer. These unnecessary and unplanned hospital admissions can often lead to further complications and a decline in quality of life. A contributing factor to fragmentation is the separation of health and social care, with their own separate budgets, different commissioning responsibilities and priorities, and to whom they are accountable.

In Hammersmith and Fulham we support moves towards an integrated health and social care budget. Through the use of the Better Care Fund (BCF) we have led the way in health and social care integration through our joint work with Hammersmith & Fulham Council. For example, Department of Health guidelines recommend a minimum investment in the BCF of £13m for 2015/2016. By mutual agreement with our Health and Wellbeing Board colleagues, we supported a much larger fund of £80m. This supports specialist homecare services, community rehabilitation, 7 day social work services, personal health budgets for mental health and children's services and many other areas of joint work.

The largest area of investment in the BCF relates to further development of a pioneering integrated intermediate care service which we have been working closely with LBHF to develop over the last 18 months, the Community Independence Service (CIS). The CIS provides a rapid social, physical and psychological assessment and care service for individuals who are at risk of admission to hospital, and provides assessment within 2 hours of referral. Through daily and weekly multi-disciplinary team reviews the team, together with the patient and their carers, devise an integrated care plan. This plan provides a tailored package of nursing, medical and social care support to care for the individual within their own home. The team also works to support in-reach services, going into local Trusts and identifying patients who could be better cared for at home or in residential care.

Senior officials at NHS England, Monitor and the Department of Health have visited the CIS because it is seen as an example of good practice in responding to the need of this population group. As a direct result of the service's success, the hard work of local health and social care professionals, and the positive feedback from patients and carers from April 2015 the CIS will operate across the Tri-Borough (Westminster, Kensington & Chelsea, Hammersmith & Fulham). This is the first time we have contracted for a lead provider and appointed Imperial Healthcare NHS Trust to run the CIS from April 2015. As lead provider the Trust will work with partners in primary, community, secondary and adult social care across the three boroughs to take on the responsibility for caring for our most vulnerable patients.

We believe that these initiatives are having a positive impact on the health and experience of our residents. However, isolating the specific impact of out of hospital initiatives on emergency admissions is notoriously difficult to do, particularly over relatively short time periods. Our out of hospital strategy represents a long term plan, and we will continue to monitor, along with outside agencies including the Nuffield Trust, its impact over time.

3. Implementation of service changes as part of Shaping a Healthier Future

In addition to investing in out of hospital services it has also been our objective to address some of the local challenges faced within the configuration of our acute services. For Hammersmith and Fulham our first priority has been to address the quality concerns arising from Hammersmith Hospital's Emergency Department (ED).

This ED was one of the smallest in the NHS. Consequently it had great difficulty in attracting staff (experiencing a high vacancy rate for the last two years) and in providing the standards of emergency care we expect for our residents. Unusually it was not staffed by specialist trained emergency care doctors and the presence of senior clinicians was one of lowest of any ED in London. The unit was also unable to provide care for children. An audit conducted by senior clinicians from elsewhere in London concluded that *"many of the adult emergency services standards for acute medicine were not met at Hammersmith Hospital."* (http://www.londonhp.nhs.uk/wp-content/uploads/2013/06/Hammersmith-Hospital-Quality-Safety-Audit-Report_FULL-April-2013_FINAL.pdf). In addition the adjacent Urgent Care Centre (UCC), treating 70-80% of all ED patients was only open for 12 hours a day.

Since the closure of the Hammersmith ED in September 2014 the UCC is open 24 hours a day seven days a week and has continued to provide a safe service. Should anyone attend the UCC and require further treatment within an Emergency Department, they will be transferred to the specialist ED at St Mary's, or to other EDs at Charing Cross or Chelsea and Westminster. As a result of the successful campaign to inform people about closure of the ED at Hammersmith Hospital, very few patients are arriving at Hammersmith UCC who need to go to an Emergency Department.

As a result of the changes:

- We now have a safe, sustainable UCC at Hammersmith Hospital.
- We have increased UCC access at Hammersmith to 24 hours a day, 7 days a week.
- Six additional ED consultants have been recruited at the St Mary's site to ensure that our sickest residents are cared for by the most senior clinicians.

Conclusion

The changes at Hammersmith Hospital have resulted in a safe and sustainable urgent care centre for local residents. In addition we are making significant investments in improving capacity in primary care and expanding the range and quality of services provided in the community. These are part of our strategy to create a sustainable and consistently high quality health system to meet the needs of our residents.

As the implementation of SaHF continues to progress during 2015 and beyond the CCG will continue to build on experiences of implementing SaHF to date, including good practice and lessons learnt. We will ensure that any planned changes to services will continue to receive rigorous clinical assurance. We will only proceed when we are confident that any such changes deliver safe and appropriate services for our residents.

The public consultation we undertook for SaHF demonstrated overwhelmingly that what our residents want most is high quality healthcare for their families, communities and them as individuals. The primary objective of centralising specialist ED care is to improve outcomes for our population and has resulted in a net financial investment in emergency care and out of hospital services. Evidence suggests that patient outcomes are improved by increased specialist ED consultant presence. That was not (for the reasons in the letter already outlined) achieved or achievable at Hammersmith ED.

We recognise that changes to local health services can be unsettling and accept that we can always do more to articulate the benefits of each and every change to local health services.

Yours sincerely

Dr Tim Spicer
Chair, NHS Hammersmith and Fulham CCG

NHS
Ealing
Clinical Commissioning Group

3rd Floor
Perceval House
14/16 Uxbridge Road
Ealing, W5 2HL

By Email

Mr Mansifield QC
c/o Peter Smith
Room 39
Hammersmith Town Hall
London
W6 9JU

23rd February 2015

Dear Mr Mansfield,

Ealing CCG submission

Thank you for your letter of 16th December 2014 in which you invited interested parties to submit written evidence that may assist your inquiry in its consideration of the impact of planned changes to healthcare services in North West London. Within this letter, in my capacity as elected Chair of Ealing CCG, I set out a range of evidence underpinning my organisation's continued support for the *Shaping a Healthier Future* (SaHF) programme, which will ensure our patients and residents receive better quality care in the right place at the right time.

The Needs of Ealing CCG's Patients and Residents

The London Borough of Ealing is a diverse set of communities with a broad set of healthcare needs. Ealing CCG, as the sole Clinical Commissioning Group for residents registered with a GP practice within the borough is the third largest CCG in London, with a registered practice population in excess of 370,000 residents. The Governing Body of the CCG is mandated by its own constitution and NHS England (through the Health and Social Care Act (2012)) to provide high quality care to the residents of the borough.

Although broadly in line with the health needs of other CCGs within London, Ealing CCG faces particular challenges with long term conditions (LTCs) such as diabetes, heart disease and those with long term mental health conditions. In Ealing it is estimated that treating diseases related to overweight and obesity will cost the NHS in the region of £98.8 million by 2015. With a total budget of approximately £400m, this represents a significant outlay of our total healthcare spend.

Ealing is considered to be a relatively prosperous London borough. It has an overall employment rate of 70%, which is slightly higher than the London average. It has relatively high household incomes with a median income of £575/week, a large number of local businesses offering employment opportunities and high levels of property ownership. Ealing

also has marginally lower rates of people on out of work benefits of 12.1% (compared to a London average of 12.6%) and claiming jobseekers allowance of 4.1% (compared to a London average of 4.3%).

However, Ealing also has areas of concentrated worklessness, with significant income inequalities. 26,650 people are on out of work benefits in Ealing which includes 3,890 lone parents on income support, 1,530 jobseekers aged 50-64 and 1,935 (7.1%) jobseekers aged 18-24. Nearly 2,400 people have been unemployed for over 12 months. The ward of Dormers Wells is amongst the 1% most income deprived in the country. In Norwood Green 18.9% of working age residents are on out of work benefits compared with 5.4% in Northfield, and wards in the areas of Northolt, Southall and Greenford also have rates above the Ealing average of 12.1%.

Child poverty is also a significant problem in Ealing. There are 9,290 workless households in Ealing and 19.2% (15,140) children aged 0-15 living in poverty. A further 5,170 children live in working but low-income households. Numbers of children in poverty are highest in the wards of Northolt West End, Greenford Broadway and East Acton. Persistent parental low income is associated not just with poverty but also poorer health outcomes.

It is within this strategic context of long term health issues and clear areas of social and healthcare deprivation that Ealing CCG has set its commissioning intentions for previous and future years. At the forefront of these intentions has been the central commitment to ensure more patients are treated out of hospital, with the reliance on acute hospital care gradually reduced as the CCG's initiatives begin to take a long term effect.

Ealing CCG's Out of Hospital Strategy

The CCG's Out of Hospital strategy is focused on ensuring patients receive the most appropriate care in the right setting, tailored to their individual needs. As a part of its *Better Care Fund* programme of work, the CCG is committed to working with health and social care providers to meet a national target of a 3.5% reduction in non-elective admissions.

In 2012, Ealing CCG published its first major strategy document, *Better Care, Closer to Home* which set out how the fledgling organisation would prioritise investment to transform the way in which out of hospital services are delivered within Ealing. In January 2014, this was followed up with the CCG's first *Out of Hospital Delivery Strategy*..

At present, access to care and the quality of care are variable across the borough. For example; too often our care is fragmented and as commissioners we must examine how we can ensure that better care is delivered in the community in a planned and sustainable manner. We need to have more planned care and earlier interventions outside of hospital which the CCG is committed to achieve. Developing and investing in out of hospital care will help us meet the changing requirements of Ealing's population and enable them to access the care they need in the most appropriate setting.

Previously we have not invested at a scale which delivers consistent and lasting change to the way care is delivered to patients of all ages and backgrounds. We have a vision which moves the system from a responsive to a proactive system that delivers care in a planned and coordinated way. The model needs to be sustainable, easy to use and well understood by users and providers. In Ealing and in NW London patients now work with commissioners and providers to co-produce models of care which are owned by all stakeholders. At the heart is the empowerment of individuals, carers and families. We have set out a number of strategic goals that we are working to deliver and standards against which we will measure our success:

1) Accessible care: care that is responsive to patients' needs and preferences, timely and accessible.
2) Proactive care: proactive planned care that is easy to access, convenient and able to utilise specialist skills where appropriate.
3) Co-ordinated care (including rapid response and supported discharge): care that is patient-centred, co-ordinated and offers continuity of care to high need patients

We will know that we have begun to succeed in this radical change when we can observe these taking place within our borough.

We want it to be easier for Ealing residents to use community delivered health and care to experience coordinated, seamless and integrated services using evidence-based care pathways, case management and personalised care planning. To achieve this, our out of hospital services need to be easily accessible and fully integrated with other services such as social care and mental health providers. When planning for the delivery of these services we must also ensure that these are closer to patients' homes and are aligned with other enabling services such as high quality patient transport.

We have already started to do this with the introduction of our innovative community transport pilot, which helps to transport vulnerable residents from their home to GP appointments. The service, provided by Ealing Community Transport (ECT), is unlike a regular bus or taxi service, in that the driver can be made aware of any special requirements a user might have and make sure the transport service is able to meet their individual needs. This service also allows a user to be accompanied by an escort or carer if required. This service has been well received by our patients and is helping to reduce missed appointments.

Since our formation, the CCG has begun to develop an emerging vision for care across Ealing and has worked with our partners to develop a set of design principles and success factors. We are now working to implement our plans to improve the integration and co-ordination of health and care for patients across Ealing.

The CCG is only part way through the full implementation of this programme and there is much work to do to ensure our long term goals can be achieved. I am delighted to report however, that a number of early successes can already be seen thanks to the diligent work of NHS and social care staff within the local area.

Initial success resulting from implementation

GP network establishment has continued at a strong pace across the borough. The organisation of practices into networks across Ealing, has enabled our GP practices to form collaborations which prioritise the needs of those with long term conditions. By enabling the CCG to commission care for a patient population we want to provide equity of access to all residents in Ealing.

Integrated care for the elderly (ICE) service has delivered strong results for integrated, intermediate care which has kept over 1,000 patients out of hospital and improved the quality of care for our patients since its launch.

Our pulmonary rehabilitation service provided by Ealing ICO has been in operation for over a year now and has enabled over 400 patient contacts for the delivery of an enhanced model of care which would once have been delivered from a hospital setting.

New diabetes pathways and clinics have been funded with additional investment to enable

Ealing patients with diabetes to access specialist diabetes experts in a wider range of settings. In the year 2013/14 we moved over 100 diabetes patients from a traditional hospital setting to new locations closer to home.

Increased investment in musculoskeletal services has improved quality, reduced waiting times for patients and lowered the requirement for hospital based care. This service now has lower waiting times and we are seeking to expand it further.

Psychiatric liaison services are in place to support patients in mental health crisis, and provide a supported discharge service to help reduce length of stay and delayed transfers of care.

The community TeleDermatology service launched in June 2014, with the aim of seing patients within ten days of a GP referral. More than 2,082 patients have been referred to the service with five hubs across Ealing bringing care closer to people's homes. 100 per cent of patients with skin conditions offered appointment within ten days. 98 per cent of patients giving feedback rated the service as "good" or "excellent."

Building on the design work begun in 2013/14, we will introduce a **community based cardiology service** that is focused on improving clinical quality outcomes across the borough.

Raising the quality of services for those patients who do require acute hospital care

For those patients who require hospital care, the CCG wants to commission the services which best deliver the greatest patient outcomes combined with high quality patient experience. When asked to describe what 'quality of care' means to our patients and representatives, their views can most commonly be grouped into three discrete categories:

Access – our patients do not want to wait for a long time in order to receive their treatment. In common with all other CCGs in England, Ealing seeks to achieve this and measure its progress using the Referral to Treatment (RTT) and A&E 4-hour wait target.

Estates – our patients often tell us that their experience of accessing NHS services, particularly in hospital settings, is lower than it should be due to the ageing and under-maintained quality of the buildings from which services are delivered.

Workforce – in common with most patients, our residents measure the effectiveness of their overall experience with the NHS by their clinical outcome and any improvement in their overall level of health and wellbeing. This often leads to a patient expectation that their care should be delivered by a consultant and not by a junior clinician.

The CCG, through the implementation of the SaHF programme, aspires to gain significant improvements in all three of these areas by consolidating emergency and inpatient services onto five 'Major Hospital' sites.

We felt that this issue was so important and sensitive to the needs of Ealing people that we took the unusual step of issuing a referendum on the changes to all GP practices which comprise our Council of Members (all 79 GP practices within the borough). Each practice received one vote for every 1,000 registered patients, meaning that 379 votes were available, in line with Ealing CCG's constitution. An overwhelming majority; 258 weighted votes; (68.1% of the total available) agreed with the statement:

Do you agree or disagree that there are convincing reasons to change the way we deliver healthcare in North West London including:

- *New standards for care in hospital and concentration of services to achieve them*
- *Delivering some services that are currently delivered in hospital more locally*

The CCG acknowledged this as an overwhelming signal of support for the changes from the local clinical community. As a CCG, we expressed our preference to retain Ealing Hospital as a Major Hospital within any future configuration of health services in North West London. Our organisation also recognised the need to reconfigure the way care is provided in order to meet the needs of our patients and residents. Ultimately, we chose to support the programme as being in the interests of all residents in North West London, including Ealing, even if Ealing Hospital was not to be a Major Hospital.

The concentration of services at five Major Hospital sites will raise outcomes through the improvement of consultant cover and greater training and development opportunities resulting from higher patient volumes. Smaller hospitals have a smaller workforce and have difficulty in providing uniform consultant skills, particularly in the emergency out of hours setting. Surgical specialties are particular problems for emergency care. Acute abdominal pain is a common presentation in A&E and requires general surgical skills, preferably with laparoscopic skills to allow investigation and 'keyhole' treatment of conditions like appendicitis more effectively with fewer complications and shorter lengths of stay. Subspecialties of urology, vascular and breast surgery are no longer considered suitable for inclusion in the general surgical on-call rota. The potential benefits from specialisation are greater for life-threatening conditions like stroke and heart attack, but is also true for less severe conditions. In 1996 the NHS Centre of Reviews and Dissemination published a systematic review showing that similar association between volumes and outcomes was also present for gastric surgery, intestinal surgery, cholecystectomy and lower limb amputation[1]. Further work has reviewed a wider range of conditions that would benefit from such concentration of services[2]. For example orthopaedic surgery on a hip has better outcomes when performed by a surgeon with that specialist interest who operates frequently[3].

The Joint Committee of Primary Care Trusts (JCPCT) which met in February 2013 unanimously agreed all thirteen recommendations of the DMBC. The London Borough of Ealing's Health Oversight and Scrutiny Committee (OSC) took the decision to refer this decision for independent review by the Independent Reconfiguration Panel. We welcomed the opportunity to meet the experts of the panel and explain to them the urgency and rationale for the need to make these changes. The IRP reported back with a full set of recommendations that the *Shaping a Healthier Future* programme should proceed with implementation of the JCPCT's decisions. In accepting these recommendations, the Secretary of State for Health (Rt Hon Jeremy Hunt) endorsed the changes and asked the programme to implement some of these changes 'as soon as is practicable'. In addition to these reviews, the programme was subject to further Judicial Review at the High Court, which was dismissed in full..

Since the meeting of the JCPCT, Ealing CCG has worked with patients' and residents' groups to agree the range of acute hospital services which should be provided in Ealing following the full implementation of SaHF. The CCG has supported a process of co-design with these groups to design a new 'Local Hospital' which will meet the needs of Ealing residents.

---

[1] NHS Centre for Reviews and Dissemination: Hospital Volume and Health Outcomes, cost and patient access. Effective Healthcare Bulletin (2) 8. 1996

[2] M Soljak. 'Volume of procedures and outcome of treatment'. BMJ 2002, 325. 787-8

[3] JA Browne, R Pietrobon, SA Olson, J' Hip fracture outcomes: does surgeon or hospital volume really matter?' J Trauma. 2009 Mar;66(3):809-14

Ealing Hospital is to be modernised and redeveloped with a multi-million pound investment to create a new 21st century facility for the local community. As confirmed by the Secretary of State for Health, it will continue to have a local A&E and 24/7 GP led Urgent Care Centre, with access to 24/7 specialist care, as well as a range of specialist services designed with – and for – the local community, such as diabetic services.

Ealing will become a new local hospital for the whole of the local population. In particular, it will improve care for elderly patients, those with long-term conditions and the most vulnerable members of the community by integrating primary and secondary care with community and social care. These changes will not happen for a number of years allowing us to develop a range of new and improved out of hospital services, capable of caring for people in and closer to their homes.

Healthcare delivery in Ealing following the closures of Hammersmith Hospital Emergency Department and Central Middlesex Hospital A&E Department

In September 2014, in line with the requirements of the Secretary of State for Health, these services were closed in a safe and planned manner.

Since the closures, our patients have continued to access urgent and emergency care services without disruption. All hospitals, including those earmarked for conversion to 'Local Hospitals' continue to provide an Urgent Care Centre service as the first point of access to acute hospital based emergency care services. The Urgent Care Centres at Hammersmith Hospital and Central Middlesex Hospital now offer an 'enhanced specification' to widen the range of conditions treatable. This ensures that Ealing patients accessing care at these sites are able to access services at Urgent Care Centres which would require Accident & Emergency access in other parts of London and England.

Changes to Ealing Hospital maternity and gynaecology services under Shaping a Healthier Future

Changes to Ealing maternity & gynaecology services will take place. The timetable for these changes has been accelerated as a result of concerns raised by the Medical Director of what was then Ealing Hospital NHS Trust. These were in regard to the future sustainability of this service given the falling number of bookings at the site. The need for change to take place rapidly is reinforced by the letter recently submitted to the programme by a number of Ealing midwives. Ealing CCG Governing Body is likely to make a decision on timings on 18th March.

We will begin in depth preparation for changes to Ealing paediatrics services, which we currently expect to take place in 2016/17. There is a gap between changes to maternity and paediatrics services to allow us to develop paediatric capacity across North West London. We are investing £6million to improve hospital paediatric facilities across the sector. The new service at Ealing will be an innovative integrated community facility, an exemplar of modern paediatric services. When complete, we will be able to provide new capacity equivalent to 127% of that currently available at Ealing Hospital.

Ealing CCG's continuing support for Shaping a Healthier Future through to full implementation of the agreed changes

As the Chair of Ealing CCG, both I and the wider Governing Body of the organisation

continue to support *Shaping a Healthier Future* as the best way to achieve the clinical standards required for delivering the outcomes our patients require. We have always been clear that we would have preferred Ealing Hospital to become one of the five Major Hospitals in the new configuration. From both a clinical and financial analysis however, the Governing Body chose to support the whole programme of change as being in the best interests of all residents in North West London. It is also why, as previously advised, we are strong advocates and supporters of the new Ealing hospital that is to be developed. My clinical colleagues and I who sit as elected representatives on Ealing CCG's Governing Body continue to believe and assert that these agreed changes are in the best interests of the patients and residents of Ealing.

During the life of the SaHF programme, our plans for implementation have quite rightly been subject to extensive scrutiny. Not only have we held extensive events and healthy debate with our local population, the SaHF proposals have been independently reviewed by:

- Independent clinical experts from the Independent Reconfiguration Panel
- A High Court Judge
- The Secretary of State for Health

All of these independent reviewers have endorsed the plans as either safe, in the best interests of local people, lawful or all of these.

Yours sincerely

Dr Mohini Parmar
Chair, Ealing CCG

NHS West London Clinical Commissioning Group
Covering The Royal Borough of Kensington & Chelsea and Queen's Park & Paddington in the City of Westminster

NHS
West London
Clinical Commissioning Group

15 Marylebone Road
London NW1 5JD

By Email

Mr Mansifield QC
c/o Peter Smith
Room 39
Hammersmith Town Hall
London
W6 9JU

23 February 2015

Dear Mr Mansfield QC,

NHS West London CCG submission

Thank you for giving NHS West London Clinical Commissioning Group (WLCCG) the opportunity to submit evidence to your inquiry. This letter, and the supporting documents enclosed, provides evidence to demonstrate that we are committed to the Shaping a Healthier Future programme, and that we are able to commission and provide the services that meet the needs of residents across North West London.

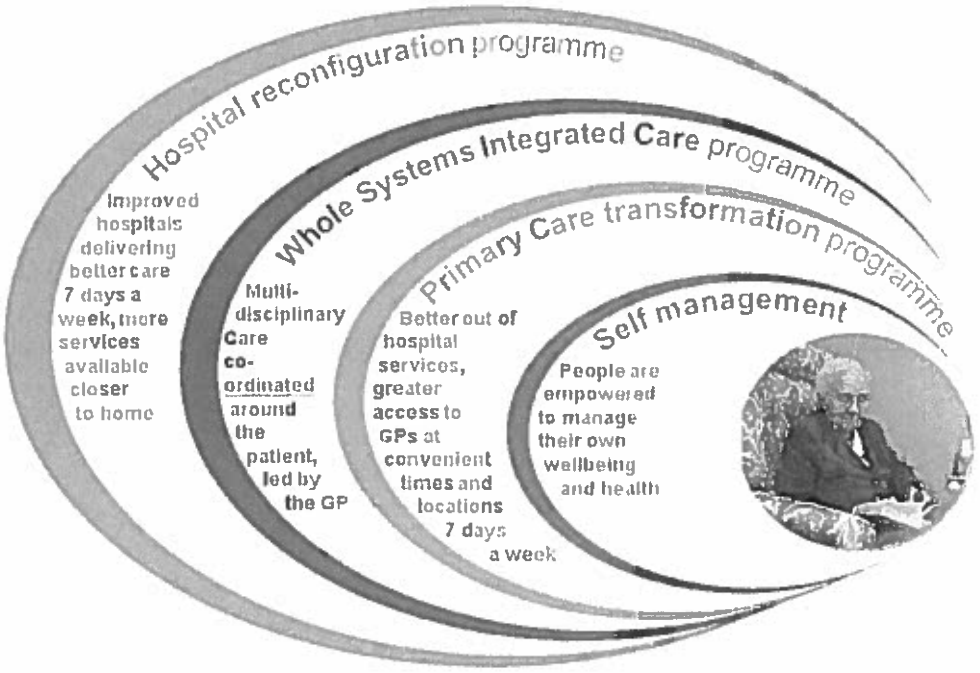
The GPs of West London CCG have served the local community for many years, care passionately about the services we provide and the challenges we face as people live longer and the population of London increases. We remain committed to the principles of centralising specialist hospital care onto specific sites. At the same time, we continue to invest in out of hospital care so that we can prevent avoidable visits to acute care and A&E.

In 2012 we developed our '*Better Care, Closer to Home*' strategy which demonstrates our longstanding commitment to providing high quality community services. Our key commitments are to:

- Develop interventions that empower patients to stay healthy for longer, prevent ill-health and reduce health inequalities,
- Develop a greater range of well-resourced services in primary and community settings, designed around the needs of individuals,
- Ensure quality improvement and innovation across the whole system - this is central to our plans to deliver better value for money in the process,
- Put the needs of patients first to ensure the coordinated and integrated delivery of health and social care.

These commitments support patients to access care closer to home, maintain their health, and prevent avoidable visits to acute care and A&E.

WLCCG, as part of the wider North West London NHS, is involved in a number of transformational programmes, all of which align in a way that will help us to achieve our vision of '*Better Care, Closer to Home*'. Our key programmes are outlined below.



Transforming Primary Care
Our practices provide high quality accessible primary care services and we are committed to supporting them to achieve our '*Better Care, Closer to Home'* vision. To support this, we have invested in four GP practices and two walk-in centres that are open during the weekends and available to all patients.
Through the Prime Ministers Challenge Fund (PMCF), we have further invested in 28 practices, offering telephone consultations as an alternative to face to face appointments. Five of these offer email consultations, and 22 offer online appointment booking.
We are committed to ensuring better access to primary care and in 2015/16 we aim to offer all our patients urgent appointments within four hours, and they will be able to access primary care anytime between 8.00am and 8.00pm.

We are excited by our emerging GP Federation which will incorporate all of our practices and has aspirations to be a credible provider of choice for innovative primary care services, including provision of Out of Hospital services, bringing services previously provided by hospitals into the community

We are confident that these initiatives will provide services for patients that offer more convenient and continuous care than using A&E services.

Whole Systems Integrated Care
Our Putting Patients First Initiative builds on the principle of care planning, case management and integrated working, and all of our practices have regular Multi-Disciplinary Team (MDTs) meetings, which include input from social care.

In addition to this, we commission Age UK Kensington & Chelsea to provide 13 Primary Care Navigators based in local primary care practices to help patients aged 55 and over with complex physical and/or mental health needs navigate their way around the health and social care system. They provide information to support patients' needs and can also co-

ordinate their care. This improves the take-up of services, and also reduces social isolation and can provide feedback to their GPs concerning any gaps.

During the first quarter of 2015, we are launching our Whole System model of care for Older People - initially in the North focusing on creating a dynamic, multi-professional hub at St Charles. This is a new model of primary care, where the GP is central to caring for older people and is able to offer care planning appointments with rapid access to a number of other providers including social care and the third sector. In quarter two we will launch our model in the South. The key principles outlined in the model are:

1) Centred around the holistic needs of the service users and carers, involving them in all decisions while providing simpler access and a shared care plan;
2) Personalised and tailored to changing health as well as social needs, covering planned as well as reactive needs and one that empowers self-care;
3) Has clear point of accountability (both for clinical and non-clinical outcomes) with a core team that reflects user's needs and helps coordinate their care;
4) Is supported by a number of local operational whole systems bases where joint teams work on a day to day basis coordinating the care and tracking outcomes;
5) Helps coordinate the services (via the base) as needed from different organisations, on behalf of the service users and their carers;
6) Is brought together by shared cultural values and ethos, organisations working as an Accountable Care Partnership that is commissioned to single set of outcomes and is enabled by shared systems and incentives.

At the heart of our Whole Systems Model is the newly commissioned Community Independence Service (CIS). This will deliver more rapid and responsive out of hospital care for people with acute needs; care will be provided by health and social care teams working together in a co-ordinated way. The tri-borough CCGs (Central London, West London and Hammersmith & Fulham CCGs) have commissioned a single provider to manage the new financial investment of £1.7m (to health providers) over 2015/16 to ensure appropriate staffing levels for the expected increase in referrals and delivery to the new specification across all boroughs. The CIS will deliver more rapid and responsive out of hospital care for people with acute needs which will be provided by health and social care teams working together in a co-ordinated way.

Through the Better Care Fund, we will see an increased investment in neuro-rehabilitation community and bed based capacity, and extension of the community rehabilitation period up to 12 weeks in the community including homecare. We have also developed self-management and peer support programmes/interventions, with a focus on those with chronic obstructive pulmonary disease (COPD), cancer, diabetes and, dementia; and we have extended Personal Health Budgets to adults with long-term conditions. We are working on an integrated Adult Social Care and primary care IT system.

Acute services in North West London

Our Accident and Emergency departments have done an incredible job this winter to deliver even more care than ever. We have already increased senior cover with six more A&E consultant posts across Imperial College Healthcare Trust's A&E sites.

Chelsea and Westminster Hospital remains one of our flagship hospitals, and we are proud to commission services from it. We are constantly seeking improvements to the site, investing in an expanded A&E services, adding more inpatient beds as well as expanding the critical care capacity with a new Intensive Care Unit.

Urgent and Emergency Care in North West London

Urgent Care Centres play a vital role in providing care when patients really need it, but when their condition isn't life-threatening. We now have nine 24/7 urgent care centres including St Mary's, Chelsea and Westminster, and Charing Cross hospitals.

Our Better Care, Closer to Home strategy has rapid response to urgent healthcare needs as one of our key priority areas. We continue to work to ensure that patients requiring urgent or emergency care are treated in the appropriate timeframe and setting for their needs. By using services in the community, such as those described in this letter, we are working to reduce unnecessary Urgent Care Centre and A&E attendances and avoidable hospital admissions.

During 2014/15 we are looking at ways to improve NHS 111 and have commissioned a 'GP in the room' pilot over winter to enhance pathways for complex or vulnerable patients. We will also commission local health champions to support the community to understand how best to access urgent care, including encouraging patients to use their local GP practice as an alternative to secondary care services.

We will be holding health roadshows in the spring of 2015 to convey these messages to as wide an audience as possible. We are also developing a self-care website, which will include helpful information about urgent care, to support patients with choosing appropriate services.

Based on monitoring of services commissioned using 'winter pressures' funding during 2014/15, we will commission on a recurrent basis those services that can be shown to have contributed sufficiently to the effectiveness and efficiency of the whole system to make baseline funding a worthwhile investment. The GP in the room was an example of this; evaluation of the project will be presented to us later in the year, and will inform our future commissioning decisions.

I trust that the above reassures you of our on-going commitment to supporting the Shaping a Healthier Future agenda across North West London and locally in West London.

Yours faithfully

Fiona Butler

Dr Fiona Butler
Chair, NHS West London CCG

Shaping a healthier future

NHS

North West London Collaboration of Clinical Commissioning Groups

15 Marylebone Road
London NW1 5JD

Sent via Email

23 February 2015

Dear Mr Mansfield,

We are writing to you, on behalf of the *Shaping a healthier future* Programme Board. This is in response to the call for evidence from the Independent Commission and in particular your letter dated 16th December in which you called for evidence with regard to North West London's *Shaping a healthier future* programme.

As you would expect from a programme of this nature, there is a significant weight of material setting out in detail the local needs and case for change, how we identified the changes that would address these needs and how we are taking these forward. Relevant programme documentation on the case for change and decision making can be found on our programme website at www.healthiernorthwestlondon.nhs.uk and on the websites of the eight NW London Clinical Commissioning Groups (CCGs).

For ease of reference, this letter provides a summary of the Programme and its progress to date and we have provided links to the most relevant materials for you to refer to.

The case for change

Shaping a healthier future is a clinically-led programme designed to improve the quality of care for the residents of North West London. It was set up to address a range of challenges facing the local health economy (and the NHS more broadly) and to meet changing patient needs, which are placing ever greater demands on the local NHS. People are living longer, the population as a whole is getting older, and there are more patients with chronic conditions such as heart disease, diabetes and dementia. More needs to be done to improve care and prevent ill health, and improvements need to be made to ensure better, consistent access to high quality care. Patient needs are not being best met, with our hospitals unable to provide the 24/7 consultant-delivered care required under London quality standards. There are too many hospitals with low quality buildings.

The *Case for Change*, published in January 2012, provides specific details of the challenges which the programme was set up to address. Clinical leadership is central to the programme, including four Medical Directors (from both acute and primary care) leading through the core Programme Executive, a senior Clinical Board representing Medical Directors and CCG Chairs from across NW London, and pan-NWL clinical working groups focusing on specific services and models of care.

The *Shaping a healthier future* changes

In North West London our clinicians have developed one of the most ambitious visions for health and care transformation in the country. Our aspiration, driven by clinicians, is for an outcome-based, integrated health and social care service centered on the needs of the citizen.

Prior to the establishment of CCGs in April 2013 the process was run by the predecessor Primary Care Trusts (PCTs) in NW London, with the decision making body being a joint committee of those Primary Care Trusts (along with neighbouring Wandsworth, Camden and Richmond PCTs) . Following extensive engagement and consultation the *Shaping a healthier future* programme put forward recommendations. The Joint Committee of PCTs (JCPCT) met in February 2013 and made the following decisions:

- We would invest over £190m more in out-of-hospital care to improve community facilities and the care provided by GPs and others.
- The five major acute hospitals with a 24/7 A&E and Urgent Care Centre would be: Chelsea and Westminster; Hillingdon; Northwick Park; St Mary's; and West Middlesex.
- Central Middlesex Hospital would be developed in line with the proposed local and elective hospital models of care, and would also include a 24/7 Urgent Care Centre.
- Hammersmith Hospital would be developed in line with the proposed local and specialist hospital models of care, and would include a 24/7 Urgent Care Centre.
- Both Ealing and Charing Cross Hospitals would be developed in line with the proposed local hospital model of care, and would each include a 24/7 Urgent Care Centre. The JCPCT also recommended that further proposals for these two hospitals be developed in future by the relevant CCGs.
    - *Following the review by the Independent Reconfiguration Panel, the Secretary of State announced that the A&Es at Ealing and Charing Cross "should continue to offer an A&E service, even if it is a different shape and size to that currently offered". As per his guidance, we will develop that in line with the Keogh review of Accident and Emergency Services.*

These changes had been widely consulted upon and local clinicians agreed that they would deliver better care for the people of NW London. Please see the papers from that meeting and in particular the Decision Making Business Case (DMBC), which includes the CCG out-of-hospital strategies, for the rationale behind these proposals. This vision for the future of healthcare in North West London is being taken forward by eight CCGs which are made up of GPs from NW London's eight boroughs.

Post-decision delays

Following the JCPCT decision the programme was subject to two different external reviews:

- **Judicial review** – the High Court rejected the case brought by Ealing Council to seek to halt the *'Shaping a healthier future'* programme of planned improvements to patient care across North West London
- **Independent Reconfiguration Panel** (IRP) review – following referral by Ealing Overview & Scrutiny Committee, the Secretary of State commissioned an IRP review of the programme.

  On the advice of the IRP the Secretary of State supported the *Shaping a healthier future* recommendations in full, but also determined that changes to A&E services at Hammersmith Hospital and Central Middlesex Hospital should take place "as soon as practicable". Local clinicians strongly supported the decision of the Secretary of State, and NW London has proceeded with implementation of this decision.

Implementation plan – overview

The DMBC included a high level five year implementation timetable and the recognition that change would take considerable time to deliver. In particular, shifting care from acute setting into the community is not straightforward. North West London's out of hospital development plans are innovative and pioneering – as reflected in the award of integrated care pioneer status to North West London in 2013 – but there is also recognition across the system that these changes will take several years to put in place.

The external reviews (namely, the judicial review and Independent Reconfiguration Panel review) which the programme was subject to in 2013/14 delayed the start of implementation of the hospital reconfiguration programme, as programme resource needed to be diverted to responding to these challenges.

Clinical quality is always our paramount consideration in planning and delivering any changes. Clinicians, the IRP and the Secretary of State all felt some changes should happen quickly. The JCPCT were clear that we should not stick rigorously to a pre-agreed implementation timetable and that timing of changes should be determined through an assessment of the safety, quality and sustainability of current services, the readiness of acute providers who will receive additional activity, and the trajectory of the delivery of out of hospital services in reducing admissions.

Implementation to date
Changes to emergency services at Hammersmith Hospital and Central Middlesex Hospital

The Secretary of State's decision that changes to emergency services at Hammersmith Hospital and Central Middlesex Hospital should take place "as soon as practicable" was taken in response to increasing clinical safety risks associated with maintaining these services, as identified by the IRP during their review. This clearly took priority over our initial plans to hold back on changes until sufficient out of hospital development had taken place. For that reason, in planning the change we did not apply the assumptions around reduction in hospital length of stay or reductions in admissions made in the DMBC.

Following the decision of the Secretary of State, the programme led detailed planning work between CCGs and providers and identified that the earliest

practicable date that changes to emergency services at Hammersmith Hospital and Central Middlesex Hospital could be made would be September 2014.

Following extensive assurance by local CCGs and NHS England (for examples of assurance see Brent CCG and Hammersmith CCG Governing Body papers) these changes were taken forward as planned, with both emergency departments closing on 10th September 2014. This was achieved with high levels of public awareness via a joint programme / Trust communication campaign; including communications materials in ten different languages. Both closures took place safely.

In common with the rest of the country, there has been a dip in A&E performance in NW London during Autumn 2014. Whilst analysis of the cause of the dip in performance is still underway, preliminary findings suggest that the re-distribution of activity was largely as modelled, but there were peaks in demand which put the providers under pressure. This is consistent with what has been seen elsewhere in the English NHS over the course of the most recent winter. Pan-NWL collaboration was put in place prior to the closures to manage peaks in demand and performance through a daily call and weekly Operations Executive. This enabled surges to be managed and any necessary action to be taken quickly with involvement from key stakeholders. A new A&E department opened at Northwick Park in late 2014, which has helped alleviate specific issues at that site.

Despite the dip in performance, clinical leaders are confident we are now running a safer system – for example, more patients across North West London are being seen and admitted or treated and discharged within 4-hours or arrival at A&E now compared to last year. Performance nationally dipped over the winter but in the period October to December 2014 the North West London sector was the highest performing in London at 92.87% for A&E performance and was above both the London and the national average performance for the quarter.

Because the Secretary of State decided that these changes should be made quickly, it was always recognised that we would be unable to deliver all planned out of hospital improvements in Brent and Hammersmith & Fulham before these changes were made – it is clear in the DMBC that these improvements would take a number of years to implement and to deliver shifts in activity. Recognising this, clinicians agreed that to support the changes to emergency services at Hammersmith hospital and Central Middlesex hospital, the priority for out of hospital development should be the enhancement of nearby Urgent Care Centres (UCCs) to the *Shaping a healthier future* specification. Hammersmith Hospital, Central Middlesex Hospital, Charing Cross Hospital and Northwick Park Hospital are all now operating to this specification, which included opening 24/7. Plans are also in place to implement this specification on the remaining NW London sites.

Improvements to out-of-hospital care

The eight North West London CCGs each agreed their own out-of-hospital strategy, tailored to the needs of their local residents as part of the DMBC. Each CCG has made significant progress in implementing their strategy since the JCPCT decision in February 2013 and has delivered tangible improvements as a result. These include changes across primary care, community care, integrated care and mental health. In total it is estimated that £90m has been invested in out of hospital services in 2013/14 and 2014/15 to date.

Each of the eight North West London CCGs is writing to you separately in response to your call for evidence with further detail of their progress in implementing their out of hospital strategies.

Planned capital investment in hospital and out-of-hospital care setting
The Programme planned significant capital investment in both acute hospital sites and out of hospital settings in order to regenerate hospital and primary care across NW London.

Significant progress has been made in this area since the JCPCT decision:

1. Outline business cases are in development for investment in "community hubs" in Brent, Harrow, Hounslow, Hillingdon, Central London, West London ,and in "local hospital hubs" in Hammersmith and Fulham and Ealing.
2. Draft outline business cases have been developed for investment in acute hospitals across North West London:
    a. To provide additional capacity at St Mary's Hospital, Chelsea & Westminster Hospital, West Middlesex University Hospital and Hillingdon Hospital.
    b. To support the development of Hammersmith Hospital as a hub for a range of specialist services and complex surgery.
    c. To support the development of Central Middlesex Hospital into a local elective centre.
3. To redevelop Ealing Hospital and Charing Cross Hospital – these redevelopments form an important part of the out of hospital strategies for Ealing CCG and Hammersmith & Fulham CCG respectively, with the development of "local hospital hubs".

An "Implementation Business Case" (ImBC) is being developed which provides a single consolidated view of all these investment requirements and this will be used to seek assurance and approval through the necessary external routes (e.g. NHS England, the Trust Development Authority and the Treasury). *Once the ImBC is agreed, further work can be taken forward.*

Next steps for Shaping a healthier future

We remain confident that the *Shaping a healthier future* proposals will deliver improved care for local people. The SaHF programme continues to be clinically-led through the eight North West London CCGs and its Clinical Board and is supported by local clinicians. In addition we continue to work closely with patient representatives as we plan and deliver change. Our Patient and Public Representative Group is a core mechanism for this; it is chaired by a lay member and has representatives for all North West London boroughs. More broadly, we have a pan-North West London Lay Partners Forum which supports and informs our transformation work, with co-design a core working principle.

We expect that our implementation timetable will continue to evolve in response to local circumstances; however, our current expectation is that in 2015/16:

- Changes to Ealing maternity & gynaecology services will take place. The timetable for these changes has been accelerated as a result of concerns raised by the Medical Director of what was then Ealing Hospital NHS Trust. These were in regard to the future sustainability of this service given the falling number of bookings at the site. The need for change to take place

rapidly is reinforced by the letter recently submitted to the programme by a number of Ealing midwives *(enclosed is a copy of that letter and the programme's response)*. Ealing CCG Governing Body is expected to make a decision on timings on 18th March.

- We will begin in-depth preparation for changes to Ealing paediatrics services, which we currently expect to take place in 2016/17. There is a gap between changes to maternity and paediatrics services to allow us to develop paediatric capacity across North West London. We are investing £6million to improve hospital paediatric facilities across the sector. The new service at Ealing will been an innovative integrated community facility, an exemplar of modern paediatric services. When complete, we will be able to provide new capacity equivalent to 127% of that currently available at Ealing Hospital.
- We will secure approval of the ImBC and proceed with development of business cases for capital investment.
- We will continue to plan 19 new "community hubs" in primary care. Improvements to primary care will mean that most boroughs will be offering weekend opening and 8-to-8 services and that tele-appointments will be available. Patients will be able to see their GP health record online.
- The CCGs, working with NHS England and supported by the London-wide LMCs, will develop joint co-commissioning of primary care, which we expect to be fully operating in April 2015.
- We will take forward the recently launched pan North West London mental health and wellbeing strategy. The strategy will build on the multi-agency partnership work we have been doing to transform and integrate services and will include a major redesign of mental health crisis care.
- GPs in NWL are forming federations and networks to begin to improve access to care.

More details can be found in our five year strategy.

A review into the changes to emergency services at Hammersmith Hospital and Central Middlesex Hospital was commissioned by NHS England and is expected to be published shortly. The programme also ran a lessons learned workshop with stakeholders involved in the process. The report on this workshop and the findings of the NHS England review will be fed into future implementation planning.

As part of the changes to emergency services, the programme put in place additional quality and performance monitoring of emergency services through a pan-North West London Operations Executive. This continues to meet and in preparation for maternity changes, a Maternity Quality Dashboard is in development.

Local clinicians have worked tirelessly to agree and deliver changes that we know will result in better care for our patients. But change in the NHS often raises concerns and this programme has understandably met with significant opposition from a range of stakeholders who are concerned about the future. Despite our best efforts to communicate with these stakeholders the benefits which we know this programme will deliver, there remain misconceptions about this programme.

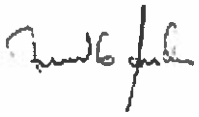
As we move forward in the implementation of these changes we welcome this opportunity for a fresh perspective on our work.

Yours sincerely,

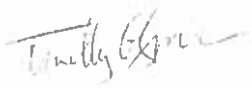
Mark Spencer,

Susan La Brooy,

Mike Anderson,



Tim Spicer



Medical Directors,
Shaping a healthier future programme

NW London Group of Local Authorities' Enquiry Chaired by Michael Mansfield QC.

Impact of NHS 'Shaping a Healthier Future' policy on acute care for NW London patients.

WRITTEN JOINT EVIDENCE BY FOUR BRENT CCG LOCALITY PATIENT PARTICIPATION GROUP CHAIRS.

(This submission is endorsed by the Steering Group of Brent Patient Voice.)

Dated 21 February 2015

Contents

Appendix 3: correspondence with Imperial College NHS Healthcare Trust.

Appendix 4: newspaper items from 2006

Appendix 5: table of LNWHT A/E response times.

1. Context.

1.1 NHS Brent Clinical Commissioning Group (CCG) constitution sets up the 5 locality Patient Participation Groups (PPGs) for Harness, Kilburn, Kingsbury, Wembley and Willesden of which we are four of the chairs elected by the local patient/public members. The constitution of Brent CCG establishes an Equality, Diversity, Engagement and Diversity (EDEN) Committee of which we are ex *officio* members.

1.2 Both before and after the commissioning of Brent CCG on 1 April 2013 we have closely followed the attempted implementation of the SaHF policy by Brent CCG and its implications for the NHS hospitals used by Brent NHS patients. We have extensive joint experience of public administration and cross party political views. Nan Tewari is a former NALGO Trade Union official and Human Resources specialist. Robin Sharp CB is a retired Under Secretary at the Department of the Environment. Irwin Van Colle is a Chartered Accountant and former Conservative Party Executive Councillor on Brent Council. His Honour Peter Latham is a retired Circuit Judge who sat at civil and criminal courts in Central and NW London, and previously had a specialist medico-legal practice as a barrister. We all fully support the Nolan Committee report principles of public life. None of us have any financial interest in healthcare issues other than as patients.

1.3 We have seen the Terms of Reference of the enquiry.

1.4 This written evidence focuses on our knowledge of the local impact in Brent on acute care for local NHS patients since the adoption in 2012/13 of the strategic health policy for 8 NW London boroughs, known as 'Shaping a Healthier Future' (SaHF). This policy was promulgated in the name of the 8 Clinical Commissioning Groups (CCG) (then in formation) for these boroughs, but was clearly backed at national level by the NHS and the Department of Health. Its essence was to reduce the number of acute hospitals and their A&E departments from 9 to 5, to make those remaining more highly specialised and to promote more health provision "out of hospital" and "in the community". Many regard the consultation exercise as deeply flawed and the strategy has never had whole-hearted community support. SaHF was pushed through at a time when the governance of local health provision was also undergoing major change as a result of the Health and Social Care Act 2012, though the latter is scarcely mentioned in the SaHF consultation paper.

1.5 In addition it should be noted that planning for a national programme called "Whole Systems Integrated Care" (WSIC) began as an initiative of the 8 NW London CCG's in 2013 and that aspects of it are supported by the Care Act 2014. The intention is to provide integration of health and social care at the point of delivery, involving among other things the transfer of funds from the NHS to local authority social services to compensate for cuts to the latters' budgets. Although Brent has two pilot areas for WSIC, Harlesden and Kilburn, the initiative does not so far appear to have progressed from planning to implementation. We note in passing that if successfully implemented it could be highly relevant to the need to prevent vulnerable older people from unnecessary hospital admission and speedier discharge when in-hospital treatment is no longer required. In our view current problems in this area are a major factor in the current A&E crisis.

1.6 This paper should be read together with our separate written evidence from our correspondence with London North West Healthcare Trust (LNWHT) about the crisis of delayed response times at Northwick Park Hospital Accident and Emergency Department, and with Imperial College NHS Healthcare Trust included as Appendices 2 and 3. We will not repeat our analysis and representations here that are set out in that correspondence, but we note that the Trusts and the CCG have yet to back up their claims that the initial deterioration in local A&E performance is not connected with the closure of the Central Middlesex and Hammersmith A&E's in September 2014. Indeed we have been advised that NHS England have conducted a special study into why the modeling for the closures went so wrong so quickly. To date it has not been made public. We consider that full transparency should apply to this exercise.

1.7 On 29 January 2015 LNWHT replied to our questions about the A/E funding 2009 workload marginal rate cap by a letter dated 27 January 2015 from Tina Benson Director of Operations for the Trust. This includes reference to the December 2014 Monitor/NHSE paper on the 2009 patient numbers baseline for 30% marginal rate for A/E funding by their CCGs. Some of us had the opportunity to discuss the A&E situation and measures being taken to improve it with the Trust Chief Executive Mr David McVittie, Chief Medical Officer, Dr Charles Caley and the Director of Operations on 29 January at their invitation. At that time performance figures against the 95% '4 hour' response time target were showing small improvements over each of the preceding 3 weeks after having been the worst in the country. See also paragraph 1.17 below.

1.8 It was not suggested at the 29 January meeting that there had been any significant adjustments to the Northwick Park Hospital A/E marginal rate baseline on their taking over the acute A/E work from Central Middlesex and Hammersmith Hospitals. The Trust leaders were adamant that they treat

patients presenting to A&E according to their needs and not to conform to the marginal rate cap funding. They accepted that this cap serves to increase the Trust deficit, while having no value as an incentive to better performance.

1.9 The Northwick Park Hospital marginal rate cap issue is reflected in the December 2014 Monitor/NHSE paper which shows that there has been a major tug of war going on behind the scenes about the setting of the A/E patient numbers baselines by CCGs, and lack of transparency about what CCGs do with the 70% marginal rate retention money intended to be applied on community measures to control A/E demand.

1.10 It is clear to us that NHSE are on the back foot in this paper. They try to defend the merit of the marginal rate cap as an effective tool to control A/E workload. But they have had to concede increased A/E funding by proposing to cut the marginal rate reduction from 70% to 50 %. This is obviously because too many localities are simply not coping with their A/E funding on the 70% marginal rate reduction.

1.11 The tensions between LNWHT and Brent CCG are vividly revealed by the minutes of the 17 December 2014 Brent CCG Quality, Innovaton, Productivity and Protection (QIPP) Committee meeting:

> 'The Clinical Directors stressed the need to use financial penalties and decommissioning to achieve better services from LNWHT and expressed great concern that despite assurances over the years from LNWHT there was still a deterioration in performance and services and that additional funding under Winter Pressures may not improve performance. A broader debate was called for to bring to the attention of the LNWH Trust the frustrations and anger the

GPs had at the service provided to their patients over the last 20 years. The GPs had no confidence in the LNWHT managerial side, nor in the manner its clinical teams run their departments, nor in the A&E service.' http://brentccg.nhs.uk/en/publications/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/356-28-january-2015 : Item 18 2.32

1.12 In the Brent situation this is one of the many factors underlying the severe pressures on Type 1 Accident and Emergency Department response times at Northwick Park Hospital since the Central Middlesex and Hammersmith Hospitals acute A/E departments were closed on 10 September 2014. Even if the Trust deficit is not permitted directly to affect the day to day emergency care being delivered it is clear to us that the marginal rate cap has been skewing the projections relied on in fixing the establishments for A/E staffing and other facilities including the number of back-up in-patient beds for A/E. This must be very bad for staff morale because it conveys the message that there is a shortfall in performance, when this shortfall lies outside the Trust's control. In view of the current substantial annual financial surplus of Brent CCG it seems to us opportune to consider a re-balancing which would in due course feed through to the benefit of patients.

1.13 Whatever measures the Trusts and their funding CCGs are now putting in hand to remedy the immediate problems (see paragraph 7.6 below) the current situation represents a major failure in planning, an activity to which the NHS devotes substantial resources. No-one has so far cited any significant extraneous factors which could not have been known or forecast when closure plans were made. This suggests that over-optimistic assumptions were built into the projections used for planning.

1.14 We recall that as early as 2006 severe staffing and financial cuts were made to the establishment of Central Middlesex Hospital, formerly a teaching hospital with an international reputation in gastro-enterology, and which had been highly regarded by its patients in one of the more deprived areas of Brent. We include as Appendix 4 material from newspaper reports from this period showing that several commentators saw this as a cynical attempt to induce poor performance at the hospital, so that at a later date it could be characterized as failing and unsafe and then planned for downgrading. In our view this is exactly what happened under SaHF.

1.15 All developed countries are struggling to cope with the cost of state funded healthcare and have different models. The UK structure of of NHS healthcare free at the point of delivery for the people of the nation was preserved by the Health and Social Care Act 2012 combined with the Care Act 2014. At the same time there was a new structure for commissioning and more scope for and encouragement of competition. The main change is that the responsibility for assessing and buying secondary and community medical care for local patients from a nationally allocated budget is transferred to CCG panels of local GP's and others subject to NHS England supervision and with an array of national and local scrutiny bodies. The adjusted competition model permits a mixed state/private enterprise provision of healthcare. NHS healthcare contracts may be awarded to the successful provider bidder. In parallel under the Care Act 2013 'Whole systems integrated care' policy (WSIC) local authorities and CCGs are required to work together to provide integrated state funded non-medical care especially on patient admission to and discharge from hospital.

1.16 'Shaping a Healthier Future' in NW London can be said to reflect an NHS

national policy of transferring as much as possible of NHS hospital out-patient care to local community NHS services ostensibly to provide 'Better Care Closer to Home' but also on a cheaper basis. The other side of the same coin is the policy promulgated especially by Lord Darzi under the previous administration of concentrating treatment of certain acute conditions such as strokes, heart attacks and cancer in very specialized units in a few major London hospitals. This policy has been shown to be successful in London in relation to strokes and possibly the other acute conditions mentioned. However it does not follow that other common conditions needing urgent admission to hospital will benefit from some form of concentration, yet this thinking seems to underpin the whole SaHF strategy. In our view it should be examined against the evidence, something that 'SaHF' conspicuously failed to do.

1.17 In NW London the attempted implementation of the SaHF package has begun, as far as the public are concerned, with a highly controversial nationally approved closing of the full acute Accident and Emergency services at Hammersmith and Central Middlesex Hospitals on 10 September 2014. The strain on the remaining local NHS hospital Accident and Emergency Departments especially for Northwick Park Hospital in Brent and the patients assessed there as Type 1 with the greatest need is revealed by the weekly NHSE published statistics on meeting the national guidance of 95% of patients being discharged or transferred within 4 hours from arrival. Wembley PPG chair and Brent Councillor Keith Perrin has been producing regular analyses summarising these figures for LNWHT and Imperial Trust from the middle of 2014 and showing the ranking of performance compared with the national position. We include the latest analysis for the week ending 15 February 2015 as Appendix 5. (NB. Ealing and NWLHT are shown separately up to 28 September 2014 and then combined thereafter as LNWHT.) Several points about these figures are noteworthy. The first is the steadiness of the attendance figures for all

the trusts and for both Type 1 and Type 3 cases throughout the period. The second is the deterioration of the Type 1 performance figures from late August/early September for both Trusts, with LNWHT ranking worst or among the worst in the country for several weeks and Imperial falling as low as 7th worst. In the week ending 15th February 689 patients at LNWHT and 473 at Imperial waited more than 4 hours for discharge, transfer or admission. If the figures for Northwick Park and St Mary's were disaggregated from those from other hospitals in their respective trusts they would almost certainly show an even worse performance for Type 1 cases at these major hospitals.

1.18 Many who responded to the SaHF consultation argued that no acute hospitals should lose their A&E departments or be downgraded to elective or local hospital status until the community facilities and treatment arrangements were put in place. The NHS gave assurances that this would be the case. For example it is stated on p.38 of the SaHF document that:

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

A parallel promise was made in Brent PCT 2012 -2013 Annual Report bottom of p. 13.

> "This is a large programme of change and final implementation will take between three to five years in total. Improvements to services outside hospital – such as GP and other local NHS facilities in the community –will happen first. **The major changes to hospital will not happen until these community facilities have first been improved."**

(NB bold type ours).

Manifestly these promises have not been delivered. It is in any case extremely difficult for the public to monitor the extent to which "better care, closer to home" is actually being provided, not least because the hard copy SaHF document devoted only 3 of its 80 pages to out of hospital proposals (chapter 11) and provided no clear baseline against which change could be measured.

1.19 A table on p.39 of the same document lists five types of out of hospital provision under somewhat nebulous headings such as "Easy access to high quality care". The third column in the page 39 table lists the reconfigured position with 5 acute hospitals, 9 urgent care centres open 24/7, clinics in the community for common specialties etc., while a fifth column provides estimates of the reduction in hospital activity from the changes described. These reductions include 110,000 hospital stays, 48,000 avoided emergency admissions and 600,000 outpatient appointments. The key question therefore is what progress has been made in providing specific new facilities outside hospitals as described in the table and how many hospital stays and appointments have been avoided as a result of them. We cannot find this information on the SaHF website and we have had no reply to our email to the SaHF team asking these questions. Yet progress in this area is central to the whole rationale of SaHF. Furthermore the lack of response to or acknowledgment of our enquiry raises the issue of to whom SaHF is accountable? Who decided that 8 NW London CCG's should combine to produce a strategy that to date does not appear to be working and who can decide that it needs urgent reconsideration?

1.20 It is outside the scope of this evidence to review the wisdom of the legislation and national NHS policies, unless they bear especially harshly on the NW London situation. It is outside the scope of this evidence to review the

current mixed state/commercial provider/bidder model. It is outside the scope of this evidence to review the proportion of national GDP or the actual budget allocated nationally for NHS medical care and for non-medical care. We do however comment on the adequacy of state funding for local NHS and care needs. We have seen the King's Fund paper published on 6 February 2015 Part 1: '*The NHS under the coalition government*' dealing with the Health and Social Care Act 2012 http://www.kingsfund.org.uk/publications/nhs-under-coalition-government. The general thrust of the critical conclusions in this King's Fund paper in our view match our own experience locally in Brent, while we endorse the call for an emphasis on care and patient safety for the future.

2. Brent CCG attempted implementation of 'Shaping a Healthier Future'.

2.1 The Brent Primary Care Trust developed a 2012 SaHF business case for 13 medical specialist hospital adult out-patient services to be transferred to community out of hospital clinics. The strategy was to start with the services thought to offer the biggest projected savings to release funds for later parts. These are all proposed as GP referral services: not walk-in. Unfortunately the 2012 business case, which is essentially about how much money could be saved by moving clinics around, does not contain any discussion of the performance of existing clinics or of the clinical pros and cons of moving specialized clinics out of acute hospitals or indicate whether there is any patient demand for changed locations for these clinics. In these crucial respects it does not follow the elementary logic required for a public sector planning exercise, which NHS England gathered together in the guidance document '*Planning and Delivering Service Change for Patients*' (December 2013): http://www.england.nhs.uk/wp-content/uploads/2013/12/plan-del-serv-chge1.pdf

2.2 Brent CCG has virtually completed implementation of its SaHF Wave 1 project with most adult out-patient services for Ophthalmology taken over by the private BMI provider starting in Autumn 2014, and most adult out-patient Cardiology taken away from other hospitals (largely Northwick Park Hospital) by the NHS Royal Free Hospital with the frequently postponed start-up date currently planned for 2 March 2015. It is much too early for us to comment on how effective these 2 new community services are, though take up for the Ophthalmology service appears to be slower than hoped for. We have no information yet as to any cost savings achieved or projected for Brent CCG, or as to actual impact on the local secondary hospitals specialist Ophthalmology and Cardiology departments or these hospital trust finances. We note that Brent CCG have had to make a substantial adjustment to their QIPP (Quality, Innovation, Productivity and Protection) financial projections through the delay of about 2 years before obtaining any projected cost savings from these new services. This delay has presumably had knock-on effects through delay in releasing funds to finance the subsequent parts of the project.

2.3 Brent CCG are still preparing their 2 Wave 2 SaHF projects:-

2.4 The proposed community Gynaecology adult out-patient service was originally to be procured through competitive dialogue like all the other 12 services detailed in the 2012 Business Case paper but in 2014 the CCG decided that no such dialogue was needed but that its design should reflect the model tested in a pilot community service in Willesden and Wembley, which seemingly began in 2010 and involved a hospital trust and a local network of Brent GP's. No report of this pilot was made public nor was it clear what led to the change of direction. In late 2014 consultants for the CCG, Mott McDonald, produced a consultation paper which contained no hard information about the strengths and

weaknesses of the existing outpatient clinics, but instead produced views from an earlier survey in 2014 of the general public which had a very low response (about 120). A report of the pilot project made in 2012 was released to one of us at the end of January 2015, after much delay, and suggested that the pilot showed relatively slight improvements on existing hospital outpatient clinics in aspects where comparisons were made. The consultation period closed before this could be taken into account and the next step will be final tendering. It is an open question as to the extent to which this project will provide a more accessible service, clinical benefits for patients or financial savings or what impact it will make on the viability of the hospital clinics who will lose patients to it.

2.5 Brent CCG propose a new integrated multi-disciplinary MSK (musculo-skeletal) adult community out-patient service. This is a completely new concept for Brent and reflects thinking in the 2006 Department of Health '*The Musculo-skeletal framework*' paper. The proposed Brent service would cover most Orthopaedic, Rheumatology, Podiatry and associated Physiotherapy adult out-patient cases, but not the most complicated. This project has also slipped by at least two years. We have repeatedly been very critical to the CCG of their illogical methodology for planning this MSK project and their failure to follow NHSE December 2013 published guidance on methodology in '*Planning and Delivering Service Change for Patients*' already referred to.

2.6 The Brent CCG delay in producing a draft MSK specification has much delayed the project together with the Integrated Impact Assessment (IIA) commissioned from Mott MacDonald. The IIA was due to be received by the CCG on 6 February 2015 but has not been disclosed at the time of writing. There has been an inexplicable reluctance by Brent CCG to examine existing models, and until recently a regrettable preference for leaving it to bidders to design the

service in a competitive dialogue process. Very recently we have been most concerned to see reports that the West Sussex CCG proposed new NHS out-of-hospital MSK service may be on the brink of collapse after the preferred bidder BUPA has announced that it intends to pull out in the light of the independent and belatedly commissioned impact assessment, which indicates that an unacceptable degree of local hospital destabilisation would be caused by the new service as so far designed. There also appear to be problems with the Circle Holdings plc Bedfordshire CCG-commissioned community MSK service which may be close to the lead provider model proposed by Brent CCG. It was reported on 7 November 2014 that Bedford Hospital NHS Trust refused to sign a contract to become a sub-contractor to Circle for MSK services in the area and proposed to compete with Circle.

2.7 The West Sussex debacle confirms our concerns about the impact of this new service on removing revenue from existing secondary hospital providers. For example it could be potentially serious especially for Northwick Park Hospital even if this Trust were the successful bidder, and more so if not. Although some of us have been members of a Stakeholder Engagement Group and a Clinical Service Redesign Group, we were not able to persuade Brent CCG to have open discussion of the proposed clinical design of this service with all interested parties well before any commercial tendering was to begin and have been openly critical of their excessive secrecy, not least because it hinders constructive discussion of problematic aspects of the changes under consideration.

2.8 We had to pursue an appeal to NHS England (London) over the limitation of patient choice and associated attempt to grant a monopoly to the successful bidder in the Brent CCG draft MSK service specification. Brent CCG have been required by NHSE to amend the draft to clarify that statutory patient choice is preserved. This has been confirmed in a letter dated 26 January 2015 from the

CCG Chief Operating Officer which also confirms that Brent CCG now with the approval of NHS England propose to abolish GP clinical freedom to refer eligible NHS MSK patients direct to the hospital of the patient's choice without any hindrance. We make this inference because in the revised draft specification we have been sent the CCG are still planning to hedge patient choice about by requiring patients to be referred to the hospital of their choice via the successful MSK provider's internal triage service.

2.9 The second part of the public consultation on this MSK project has been postponed from September 2014 to after the May 2015 General Election. Estimates of a proposed start date have been repeatedly postponed and we no longer regard them as reliable. There are important as yet unresolved issues of competition and interface between this new community out-patient service and the proposed new NW London NHS elective secondary Orthopaedic surgery service to be based at Central Middlesex Hospital.

2.10 We have no definitive news from Brent CCG of progress towards establishing their other 9 community out-patient services: paediatrics; gastroenterology; clinical haematology; trauma; dermatology; general surgery; ENT; urology and medical oncology. However, ENT, Urology, Spinal, Dermatology, Gastroenterology & Paediatrics are mentioned in Brent CCG 'Commissioning Intentions 2015/16'.

2.11 In view of the delays and unanswered questions surrounding the Wave 1 and Wave 2 projects for creating new specialist clinics in the community it would be highly desirable for Brent CCG to publish a document showing how the case for moving the remaining services out of hospital stands up against the processes and criteria set out in the primary NHSE guidance *Planning and Delivering Service Change for Patients.* It is far from clear that the clinical and

alleged access benefits for patients or the possible savings justify the upheaval and frictional costs of making the changes.

2.12 Nor is it clear that patient attendance at out-patient clinics "in the community" (which means in practice Wembley Health & Care Centre, Willesden Health and Care Centre, Central Middlesex Hospital, now proposed for the southern MSK clinic, or Sudbury Medical Centre) will prevent hospital admissions in the way that attendance at clinics at acute hospitals will not. A much more challenging aspect of care closer to home would be the provision of more minor specialist treatments at GP practices by consortia or networks of local doctors with the appropriate skills. There is little sign of this developing so far but if Brent CCG had done more to promote it instead of putting such a large effort into moving consultant-led hospital type clinics to alternative locations it might well have made a contribution to preventing admissions and pressures on A&E.

2.13 Mental Health community out-patient services have never been included in the Brent CCG SaHF out of hospital transfer programme. On querying this we have never received an answer from Brent CCG as to the rationale.

2.14 Brent CCG has access to 2 modern PFI initiative hospital buildings that are seriously under-used: Central Middlesex Hospital that is a LNWHT responsibility, and Willesden Centre for Health and Care which is a Brent CCG financial responsibility.

2.14 Initially Brent CCG formed part of an NHS NW London administrative group of Brent, Ealing, Harrow and Hillingdon CCGs (BEHH). Within a year of commencement Ealing CCG decided to leave to join a more central London NHS group and did so during 2014.

2.15 Until late 2014 Brent CCG delegated much of its healthcare commissioning executive management to a NW London Commissioning Support Unit (CSU). One of our frustrations was that we could never find out much about the functioning of this unit. Brent CCG were themselves dissatisfied with the CSU on grounds we do not fully know other than that the CCG were very critical of its communications role, and its value for money. We know very little about any changes to Brent CCG commissioning management following this change, other than that it is yet another big shake-up for a new institution now struggling with a new internal administrative set-up on top of being charged with organising the major SaHF healthcare re-organisation.

2.16 As argued by the King's Fund report already mentioned, the NHS in recent years has been very burdened with such administrative re-organisations that inevitably are distractions from managing healthcare, and disrupt consistency of long term local healthcare planning and its implementation.

2.17 We recognise the validity of the 'Shaping a Healthier Future' concept of care closer to home which is widely shared across the health community, but this means significant involvement of GP's and the resources to go with that. Our criticisms above are as to the management of the design and implementation of this policy, in particular the concentration of effort on moving outpatients clinics around. In our view this aggravates the overall defects in the delivery of acute and non-acute NHS patient care in NW London.

2.18 Any attempt to co-ordinate the closure of the Accident and Emergency Departments at Central Middlesex and Hammersmith Hospitals with the introduction of SaHF community out-patient services has been undermined by Brent CCG's delays in planning and delivering their 13 new community out-patient services and the relative neglect of community services based on GP

practices or groups of practices.

2.19 The impact of attempts to implement 'Shaping a Healthier Future' policy on acute care for patients include those on local hospitals. The delays in implementing Brent CCG SaHF policy mean that the majority of the 13 relevant hospital adult out-patient services continue as previously.

2.20 Northwick Park Hospital faces the triple whammy of losing the revenue from its out-patient cardiology service, having to provide a greatly increased A/E service that it has no control over with A/E funding subject to the NHS 2009 workload cap with only a 50% pro-rata uplift for excess patient numbers, and the potential destabilisation of its other specialist services as Brent CCG progressively withdraws specialist out-patient services under its SaHF programme. This will be mitigated if LNWHT bid for this work and are successful: aggravated if they lose it. It is a major anxiety that such hospitals may not be able to sustain their more highly refined speciality services, and associated clinical training if much of their routine out-patient service revenue is taken away. This is the so-called hollowing out effect.

3. Brent CCG Staff Turnover Issues.

3.1 As members of the EDEN Committee and in a variety of working groups, and PPG meetings we have had some productive dialogue and collaboration with Brent CCG Governing Body members and individual staff members notwithstanding our concerns about the Waves programme and the CCG culture which inhibits more meaningful patient engagement. However overall Brent CCG appears to us to have staff problems. There has been a grossly excessive staff turnover which probably reflects poor morale and staff management or unsound funding rules. For example in the Wave 2 MSK and Gynaecology project there

have been four changes of Clinical Director, three changes of Senior Responsible Officer and two of Programme Manager in the last thirteen months, completely destroying any understanding of the chequered history of the initiative. The only constants are the patient "stakeholders". Too many of the staff are inexperienced and poorly trained. Turnover is so great that many junior staff have little understanding of the work of the CCG except for the specific area of work assigned to them. It appears to us that at senior management level there is still evidence of an approach derived from a state monopoly bureaucratic mentality. In theory CCG's are answerable to a Governing Body on which local GP's have a majority, but it may be that there are still hidden top down pressures on the CCG from the administrative hierarchy of NHSE and the Department of Health.

3.2 The recent November 2014 independent report Brent CCG commissioned from a panel chaired by Dr Angela Coulter (non-medical) on delivery of its statutory patient/public engagement functions was critical of the CCG and reported that a change of culture was required. They were critical of the lack of any budget for engagement functions, and very critical that too many temporary staff were employed.

3.3 We have found it impossible to get Brent CCG fully to recognise and deliver its statutory duty under s.14Z2 of the NHS Act 2006 as amended by the Health and Social Care Act 2012 to involve and consult its patients and public on all its proposals for healthcare commissioning and changes to it. It is our clear view that Brent CCG from top to bottom regard these statutory patient/public involvement and consultation duties as no more than a token public relations gesture. We regret to say that although Brent CCG does not itself treat patients, we have found that the CCG continues to show the same resistance to patient/public challenge as that criticised by Robert Francis QC in his public

enquiry reports on Mid Staffordshire NHS Foundation Trust and which required a complete change of culture. In our view the CCG present a complacent relentless 'good news' face to the public which loses them credibility when patients contrast it with their own experience of the shortcomings of NHS care in Brent.

3.4 Such is Brent CCG's resistance to face up to independent public interest criticism of its working in its EDEN Committee that it has embarked on a rushed procedure without adequate consultation for amending its constitution to abolish EDEN although its constitutional role was never much more than advisory as a patient/public 'sounding board'. When a head of steam builds up it is rather a short -sighted remedy to tie down the safety valve !

4. Inadequacy of NHS Brent availability of GP appointments.

4.1 From our patient participation groups we know that the most common complaint about local NHS services has been the difficulty in obtaining early GP appointments, compounded by complaints about difficulties in getting through to the surgery receptionist on the telephone.

4.2 Brent CCG introduced in 2013 the temporary expedient of a pilot 'Hub' supplementary GP appointments scheme funded by them. This provides extra GP appointments at local centres on referral by the patient's own GP. The pilot scheme has been extended and changed pending the commissioning of longer contracts which are shortly to be awarded. Feedback from patients using the scheme has generally been positive but they have expressed concern about the loss of afternoon Hub slots. These have been removed because NHSE say that they should be covered under the GP contract which they administer and not

from extra funds supplied by the CCG. Initially Brent CCG declined to publicise the scheme. Even now a small survey by Healthwatch Brent reported to the Brent Council Health Scrutiny Task Group in January 2015 found that many patients had never heard of it. Practices providing Hub appointments have been concerned at low take up for certain times of day. There has been resistance by some GP practices to referring their patients to the Hub scheme.

4.3 Brent CCG have at least one 'walk in' GP centre but inconveniently located for many patients. Barnet CCG have a 'walk in' GP centre at Cricklewood on the boundary with Brent. Very few Brent NHS patients know about this facility open to all NHS patients, and Brent CCG do not publicise its availability for Brent patients, presumably for financial reasons. The same applies to the urgent care centre located at St Charles's Hospital off Ladbroke Grove. It is used by many patients in the south of Brent and is popular.

4.4 The result is that in our experience very many Brent NHS patients are frustrated when they or their family need to see a doctor, and cannot obtain an early appointment at their own NHS GP practice. One available facility is the 24 hour 'walk-in' 'Urgent Care Centre' at Central Middlesex Hospital (CMH). We are told by Brent CCG that this service has been very under-used since the full acute A/E service was removed on 10 September 2014. We are not surprised. In our experience and as reported at the launch meeting of Brent Patient Voice on 10th February 2015 very many Brent NHS patients do not know that any emergency services survive now that the former full A/E service at Central Middlesex Hospital is closed. Many of those who do know are confused about the distinction between 'Urgent Care' and full acute Accident and Emergency Department care. It needs little imagination to understand why a sick patient or a parent with a sick child decides to play safe and go straight to A/E rather than risk going to 'Urgent Care' only to be sent on to A/E with delay before start of

medical investigation on top of what at the best of times may be a 4 hour wait at A/E. Indeed it was reported by a patient at the Willesden PPG meeting on 11 February that a patient with a serious problem had been mistakenly taken by a relative to the CMH Urgent Care Centre who after tests called an ambulance but the patient died before treatment at the Northwick Park A&E could get underway. There is a common view that the nomenclature, "Urgent Care Centre", gives the impression that these facilities are able to deal with a wider range of cases than they can. A preferable alternative could be "Minor injury centres".

4.5 The other resource for a sick patient who cannot get an early GP appointment is to phone 111 or 999. In our experience very many patients have little confidence in the 'proforma questionnaire' approach used by the unqualified 111 call centre staff. Again, it is not surprising that many decide to go to their nearest hospital Accident and Emergency Department where they can be certain of seeing a doctor, even if it takes more than the target 4 hours..

5. NHS Brent CCG Finances.

5.1 Brent CCG's budget for 2014/15 is about £375 million reduced from £400 million. The Department of Health have required that this part of the former funding for Brent CCG be transferred to Brent Council to help finance the new 'Whole Systems Integrated Care' policy.

5.2 Another financial handicap for Brent CCG is that national QIPP policies require annual 'salami slicing' from its budget for 'efficiency savings'. Brent CCG currently has a substantial annual surplus projected to be eliminated by about 2018.

5.3 The NHS National Trust Development Authority (NTDA) in its report on the merger of the Ealing and North-west London Hospital (NWLHT) Trusts in October 2014 set out the financial position of the merged trusts in somewhat opaque fashion: http://www.ntda.nhs.uk/wp-content/uploads/2014/09/The-merger-of-The-North-West-London-Hospitals-NHS-Trust-with-Ealing-Hospital-NHS-Trust.pdf. The 2013/14 reported deficit of NWLHT was some £23 million but this was projected to grow to £35 million unless action was taken. The deal offered to the merging Trusts was to inject £144 million over 3 years to smooth the path of the merger. This included some £30 million of capital expenditure for the purpose among other things of additional beds to assist with emergency provision. It is not clear how this strategy is unfolding but the LNWHT leadership still appears to consider that it is saddled with a deficit, mostly not of its own making, and that this affects the morale of senior and middle grade staff. (see 1.12 below).

6. Conflict of Interest Issues.

6.1 Both nationally and locally in Brent conflict of interest issues are proving to be a fundamental problem for the Health and Social Care Act 2012 concept of putting local GPs in the driving seat for buying NHS healthcare for Brent NHS patients. Increasingly local GPs are being encouraged by NHSE and Brent CCG to form groups to acquire provider legal status with a view to bidding to obtain CCG healthcare contracts either as main provider or as sub-contractors.

6.2 This local potential conflict of interest issue is illustrated by the position of the GPs in the local Harness GP healthcare co-operative which has a complex

corporate set-up including healthcare provider entities. At least 4 of the Brent CCG Governing Body GP members are Harness GP co-operative practitioners including the Brent CCG Chair, Deputy Chair and Clinical Director. Harness already have provider contracts with Brent CCG and may be a bidder for other Brent CCG healthcare contracts. This must create difficult issues of healthcare planning for Brent CCG, and on conflict of interest management. There have been occasions at Brent CCG Governing Body meetings held in public where on some issues all the GP members (forming a majority of the CCG) have had to leave the room on declaring an interest leaving important decisions to be made just by a few Governing Body lay members and executives with voting rights.

6.3 The extent and seriousness of this potential conflict of interest problem is well focused in the NHSE 18 December 2014 revision of its mandatory guidance for CCGs *'Managing conflicts of interest: statutory guidance for CCGs'* : www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf. This includes issues on compliance with Regulations 6 and 9 of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Risk management includes the risk that a healthcare contract tainted by conflict of interest may be set aside with serious financial consequences for the CCG but more important potential disruption of patient care.

7. Gaps in Brent NHS Healthcare.

7.1 The Brent Joint Strategic Needs Assessment (JSNA) which provides statistical and other information on which to base health and social care planning appears to have been updated in December 2014 under the leadership of Brent Council, though little if any publicity has been given to the revised document. We

have not had time to analyse it, but one important finding from the previous JSNA needs emphasis: Brent has a relatively young population. Therefore the CCG has no reason to cite an "ageing population" as a general justification for its policies. This is still happening. The link for the summary of the new JSNA is: http://brent.gov.uk/media/11085556/BrentJSNA-Health-and-Wellbeing-in-Brent-Dec-2014.pdf .

7.2 For reasons of space we give no more than some examples of gaps in local Brent healthcare as we see them.

7.3 Diabetes is said to use up about 10% of NHS resources nationally. It has a high risk of mortality and irreversible serious morbidity. Brent is said to have one of the highest incidences in the country probably in part through large numbers of Indian sub-continent ethnic origin populations recognised as having a high incidence of diabetes. Type II diabetes is a preventable condition. Brent CCG and Brent Council have adopted a policy of priority for dealing with diabetes. The practical implementation of this appears to us to be mainly the addition of a small number of specialist community nurses. While we recognize that there is a strategy for public education we cannot see that it is being implemented. We suggest that a sustained major local prevention campaign is needed to make people aware of the need to reduce and avoid obesity and avoid the onset of metabolic syndrome, the precursor of type II diabetes, supported by offering tests such as HbA1c across the whole community and at early middle age. This should increase awareness of the danger of metabolic syndrome at a stage when type II diabetes is still preventable by simple self-help measures. A successful campaign would prevent avoidable serious illnesses and save money in the medium and longer term.

7.4 Brent CCG say that a majority of local patients will have mental health

problems at some time in their life. This may be less dramatic than it sounds because many will have needed no more than a short course of tranquillizer or anti-depressive medication at some difficult time in their life. Brent CCG have made mental health care a policy priority, including increased resources for cognitive therapy that is recognised as effective but very labour intensive. In our view mental illness has been the Cinderella of NHS healthcare both nationally and locally. Anyone with experience of the civil and criminal courts will be aware how many fall through the safety net of so called 'Care in the Community' and end up in court, quite apart from the misery of their own situation and its impact on their families. In our experience this mental health 'Care in the Community' is little more than a healthcare slogan. Many are unable to be allocated a Community Psychiatric Nurse (CPN), and those who are find their CPN has such a heavy case-load that the care is ineffective. We are very surprised that the Brent CCG SaHF proposals do not include any new out of hospital community psychiatric service either for adults or children and adolescents.

7.5 NHS stroke acute care in London has improved greatly in recent years through concentrating acute care into highly specialised units. The weakness is in local provision of high quality integrated specialist recuperation care and therapy, both in-patient and out-patient after discharge from acute hospital unit. Although continuing such intensive therapy is expensive it can improve quality of life and reduce dependence on carers. We have seen no proposals from Brent CCG for such a new community out-of-hospital service as part of its SaHF progamme together with its new WSIC obligations with Brent Council.

7.6 It appear to us that the well-intentioned Whole Systems Integrated Care project exists as yet mainly on paper and may not be sufficiently resourced to achieve its laudable ambitions, not least because of the current pressures on adult social care. Although the intention was to reduce demarcation disputes as

between the NHS medical care and local authority social care territories it appears that this is still a major component of the Northwick Park Hospital Accident and Emergency department response times crisis. Northwick Park Hospital Chief Operating Officer and Brent CCG previous Chief Operating Officer have reported that a bottleneck at the Northwick Park Hospital A/E department is that many patients admitted through A/E have been treated for the acute condition for which they were admitted within 72 hours but remain too frail to be discharged. These 'bed blockers' cause a back-log awaiting admission from A/E. Brent CCG have tried to reduce this problem by transferring such 'bed-blockers' after 72 hours to Central Middlesex Hospital or Willesden Community Centre for Health and Care. But it is clear from the recent A/E response times statistics that this stop-gap resource has not solved the problem. The Northwick Park Hospital Director of Operations reports that a business case has been put to NHSE for an extra 60 beds by December 2015 in addition to the 50 provided since November 2014 and has received nearly all approvals required. This is an expensive remedy and seems to amount to an admission that one of the fundamental elements of the SaHF strategy was misguided, at least in the short and medium term. A 'bed' is shorthand for a whole package of additional resources from scaled-up medical and nursing establishment, through cleaning staff, IT, consumables including drugs, and catering resources. Uncertainty continues until this business case is approved and in any case implementing it by December 2015 will be an ambitious target if new construction work is involved. Meanwhile Northwick Park Hospital has the worst Type 1 A/E response time in the country: the crisis is here and now.

7.7 Brent CCG have introduced a GP 'peer to peer' hospital referral advisory service, and repeatedly emphasise their wish to eliminate unnecessary hospital referrals in accordance with SaHF policy. They have promoted a US commercial 'Referral Facilitation Service' (RFS) to monitor referrals by individual GP's. This

steer for GPs appears to contribute to patient resorting to A/E departments on a self help basis. We have heard from various members of the CCG staff that the RFS in its original form is to be abandoned. If true we welcome this.

7.8 NICE guidance advises that all between the ages of 70 and 90 be offered NHS immunisation against shingles because about one per thousand cases prove fatal and post-herpetic neuralgia is very painful and distressing. The NHS authorise GPs to approve such immunisation. Brent NHS follow national cost control guidance by offering this immunisation only to those reaching age 70 and 79 leaving the intervening year groups unprotected. This appears to be a form of age discrimination in the face of the NICE guidance, and statutory prohibition of such inequality.

8. Hospital A/E: an NHS Success Story

8.1 NHS Accident and Emergency departments locally and nationally are a success story. The increasing numbers of patients attending of their own accord reveal that the NHS has 'built a better mousetrap'.

8.2 There is patient confidence in hospital special investigation evidence based medicine. Patient sophistication has increased. There is TV familiarity with hospital emergency services.

8.3 This trend is the mirror image of decreased satisfaction with the NHS GP service with the continuing erosion of the traditional family doctor/patient relationship.

8.4 The discreet NHS choke on secondary referrals in the absence of an

available relevant community out-patient service leads to increased presentations at A/E departments, both for immediate symptoms, and in the longer term from delayed investigation and treatment of conditions that become acute.

8.5 London Ambulance Service (LAS) lack of resources contributes to the dangerous delays before investigation and treatment at Accident and Emergency departments. It seems on the face of it absurd that the LAS should have to resort to major recruitment initiatives in Australia and elsewhere when training and people with the necessary aptitudes are available in this country

9. Conclusions.

(I) It is clear to us that there is a crisis at Northwick Park Hospital Accident and Emergency Department on response times especially for the Type 1 most serious cases as assessed by the A/E department. Nor should performance at St Mary's Hospital have deteriorated so badly in national ranking terms for a hospital that describes itself as world class. LNWHT, Imperial College Healthcare Trust and Brent CCG are not fully admitting the seriousness of this situation and the consequent risk of avoidable excess mortality and morbidity. The workload and staff establishment projections on which the provision for increased workload following the closure of the full A/E acute facilities at Central Middlesex and Hammersmith Hospitals were based have turned out to be grossly over-optimistic. We suspect that these projections were unduly influenced by over-optimistic hopes of reduced demand dictated from above in a situation where national projections showed increases in the number of babies being born and older people living longer. A major factor glossed over by planning is that the NHS can deliver closure of hospitals and beds by simple decision, but providing

for the vulnerable elderly to leave hospitals promptly rests on the decisions and efforts of a range of institutions, carers and patients themselves who are not under the control of the NHS.

(ii) There has been serious mismanagement by Brent CCG of its 'Shaping a Healthier Future' programme of transferring about 13 hospital specialist out-patient services to local community services, and as to the design of the programme. This has resulted in serious delays on the implementation of this programme with adverse financial consequences for Brent CCG but more important adverse consequences for the provision of acute and non-acute care for Brent NHS patients, and for the under-pinning of the projections for A/E care for Brent patients.

(iii) Brent CCG may have been saddled with unrealistic expectations for what they could reasonably be expected to achieve so quickly as a new scaled-down administration with teething problems. In the last 2 years they have had to bed down a new organisation, continue the routine healthcare commissioning, plan, and opted to attempt to implement the Waves 1 to 5 Out of Hospital programme, plan without reviewing its viability. They have linked with other NW London CCG's to implement an early phase of the new WSIC project, and faced further administrative re-organisations. In our view this does not excuse the over-optimistic projections for Northwick Park Hospital A/E workload signed off as recently as August 2014.

(iv) In the last 20 years the NHS has suffered from a series of major administrative 'reforms'. Successive governments have claimed that their administrative changes will solve many of the problems of the NHS. These have all resulted in disruption of existing management and distraction from long term planning and delivering healthcare. Views may differ as to the wisdom of some

of the concepts on which the 'Shaping a Healthier Future' policy is based and the optimal order for implementing them. The strategy needs review in the light of experience so far and of realistic and honest assessments of the speed with which the aspirations of WSIC can in practice be achieved.

STATEMENT OF TRUTH

The facts stated in this statement are true to the best of our knowledge and belief. The opinions are our own genuine opinions.

Signed:

Nan Tewari, Chair Harness Patient Participation Group and Brent CCG EDEN Committee Member;

Robin Sharp CB, Chair Kilburn Patient Participation Group and Brent CCG EDEN Committee Member;

Irwin Van Colle, Chair Kingsbury Patient Participation Group and Brent CCG EDEN Committee Member;

His Honour Peter Latham, Chair Willesden Patient Participation Group and Brent CCG EDEN Committee Member.

Dated 21 February 2015

Smith Peter

From: Peter Latham <peter.latham1@btinternet.com>
Sent: 23 February 2015 03:54
To: Smith Peter
Cc: tracey.batten@imperial.nhs.uk; david.mcvittie@nhs.net; ginder.nisar@nhs.net; tina.benson@nhs.net; saema.shaikh@nhs.net; sarah.mansuralli@nhs.net; kevin.matthews3@nhs.net; jenny.campbell2@nhs.net; : <r.larkman@nhs.net>; anne.rainsberry@nhs.net; nancy.luck@nhs.net; <jeevan.jayanthan@nhs.net>; RobinSharpe; NanTewari; Irwin VanColle; PerrinCouncillor Keith; GaynorLloyd; MauriceHoffman; william.oldfield@imperial.nhs.uk; cllr.krupesh.hirani@brent.gov.uk; cllr.mary.daly@brent.gov.uk; cathy.tyson@brent.gov.uk; ian.niven@brentmencap.org.uk; ColinStandfield@aol.com
Subject: Re: Mansfield Enquiry: Evidence of Brent PPG Chairs: Appendix 1

23 February 2015

Dear Mr Smith,

This is Appendix 1 to the evidence of the 4 NHS Brent CCG independent chairs dated 21 February 2015 sent to you separately.

Please reply to acknowledge receipt.

Yours sincerely, Peter Latham, Chairman Willesden Patient Participation Group.

APPENDIX 1

From: Mansuralli Sarah (NHS BRENT CCG) <sarah.mansuralli@nhs.net>
To: Peter Latham <peter.latham1@btinternet.com>; Gallagher Ursula (BHH CCGS) <ursula.gallagher@nhs.net>
Cc: Matthews Kevin (NHS BRENT CCG) <kevin.matthews3@nhs.net>; Campbell Jenny (NHS BRENT CCG) <jenny.campbell2@nhs.net>; NanTewari <nantewari@yahoo.co.uk>; RobinSharpe <Robisharp@googlemail.com>; Irwin VanColle <Irwin@thecopycentre.com>; PerrinCouncillor Keith <Cllr.Keith.Perrin@brent.gov.uk>; GaynorLloyd <gaynor@gaynorlloyd.co.uk>; MauriceHoffman <mauricehoffman.uk@gmail.com>; McBeal Deborah (NHS BRENT CCG) <d.mcbeal@nhs.net>
Sent: Sunday, 1 February 2015, 18:03
Subject: RE: Mansfield Commission Terms of Reference

Dear Peter

Thank you for your email and apologies for the delay in responding.

Brent CCG will be submitting a letter to the enquiry and we would be happy to provide you with a copy as soon as it is ready but as you can imagine, we are all working to tight timescales for the submission, despite the extension recently announced. To this end, it may not be as timely as you would wish.

We appreciate the PPG chairs will be in a similar situation but would welcome sight of your submission when it is ready also.

Kind regards,

Sarah

Sarah Mansuralli
Acting Chief Operating Officer

Brent Clinical Commissioning Group
Sarah.Mansuralli@nhs.net
Wembley Centre for Health and Care
116 Chaplin Rd, Wembley, Middlesex HA0 4UZ
Telephone: 020 8795 6485
www.brentccg.nhs.uk

From: Peter Latham [mailto:peter.latham1@btinternet.com]
Sent: 25 January 2015 10:10
To: Gallagher Ursula (BHH CCGS); Mansuralli Sarah (NHS BRENT CCG)
Cc: Matthews Kevin (NHS BRENT CCG); Campbell Jenny (NHS BRENT CCG); NanTewari; RobinSharpe; Irwin VanColle; PerrinCouncillor Keith; GaynorLloyd; MauriceHoffman
Subject: Fw: Mansfield Commission Terms of Reference

25 January 2015

Dear Ursula and Sarah,

Joint NW London local authorities' enquiry into the effects of attempts to implement 'Shaping a Healthier Future' on acute care for patients in NW London; chaired by Michael Mansfield QC

The 5 locality PPG chairs propose sending in written evidence to this enquiry. The deadline for written evidence to be fully taken into account is Monday 2 February 2015. I attach a copy of the Terms of Reference of the enquiry.

Part of our evidence will be our correspondence with LNWT, Imperial College HT and Brent CCG concerning the deterioration in local hospital A/E response times since the closure of the full acute A/E services at Central Middlesex and Hammersmith Hospitals on 10 September 2014. I have copied Professor Gallagher into this correspondence as it has gone on. You should have seen the summaries of the figures produced from the NHSE statistics by Councillor Keith Perrin, chair of Wembley PPG. You may also have seen the vivid graph produced by the group of local authorities who commissioned this enquiry.

We wonder whether Brent CCG propose putting in wrItten evidence to this enquiry either on its own or together with some larger NHS group ? If so would you be willing to send us a copy before the deadline to enable us to respond ?

We will send you a copy of any further evidence that we put in as soon as it is ready so that you have some opportunity to respond if you wish. Our priority until now has had to be dealing with the Brent CCG constitution amendment issues for the recent EDEN Committee meeting. We regret that we shall be unable to send you any further evidence until shortly before the deadline.

As independent volunteers with limited access to the relevant NHS inside information we are conscious of the risks of some of the facts and inferences in our evidence being inaccurate. We make the proposals in this letter to try to minimise the risks of such inaccuracy or any unfairness.

Kind regards, Peter Latham, Chairman Willesden Patient Participation Group.

From: Peter Latham <peter.latham1@btinternet.com>
To: ""david.mcvittie@nhs.net"" <david.mcvittie@nhs.net>; "simon.crawford@nhs.net" <simon.crawford@nhs.net>; "tina.benson@nhs.net" <tina.benson@nhs.net>
Cc: "jwalters3@nhs.net" <jwalters3@nhs.net>; "ginder.nisar@nhs.net" <ginder.nisar@nhs.net>; "saema.shaikh@nhs.net" <saema.shaikh@nhs.net>; NanTewari <nantewari@yahoo.co.uk>; RobinSharpe <Robisharp@googlemail.com>; Irwin VanColle <Irwin@thecopycentre.com>; PerrinCouncillor Keith <Cllr.Keith.Perrin@brent.gov.uk>; GaynorLloyd <gaynor@gaynorlloyd.co.uk>; MauriceHoffman

<mauricehoffman.uk@gmail.com>
Sent: Sunday, 25 January 2015, 10:33
Subject: Mansfield Enquiry|

25 January 2015
Dear Mr McVittie and Tina,

Joint NW London local authorities' enquiry into the effects of attempts to implement 'Shaping a Healthier Future' on acute care for patients in NW London; chaired by Michael Mansfield QC

The 5 Brent locality PPG chairs propose sending in written evidence to this enquiry. The deadline for written evidence to be fully taken into account is Monday 2 February 2015. I attach a copy of the Terms of Reference of the enquiry.

Part of our evidence will be our correspondence with LNWT, Imperial College HT and Brent CCG concerning the deterioration in local hospital A/E response times since the closure of the full acute A/E services at Central Middlesex and Hammersmith Hospitals on 10 September 2014. You should have seen the summaries of the figures produced from the NHSE statistics by Councillor Keith Perrin, chair of Wembley PPG. You may also have seen the vivid graph produced by the group of local authorities who commissioned this enquiry.

I have not received any acknowledgment or reply to by letter to you all dated 21 January 2015 copied below. Please note that there is an error in this letter where I refer to my letter dated 26 November 2014. This should be a reference to the unanswered questions in my e.mail letter to your Mr James Walters dated 30 November 2014 that he has promised to answer.

We wonder whether LNWHT propose putting in wrItten evidence to this enquiry either on its own or together with some other NHS group ? If so would you be willing to send us a copy before the deadline to enable us to respond ?

We will send you a copy of any further joint evidence that we put in as soon as it is ready so that you have some opportunity to respond if you wish. We regret that we shall be unable to send you any further evidence until shortly before the deadline.

As independent volunteers with limited access to the relevant NHS inside information we are conscious of the risks of some of the facts and inferences in our evidence being inaccurate. We make the proposals in this letter to try to minimise the risks of such inaccuracy or any unfairness on these public interest issues.

Kind regards, Peter Latham, Chairman Willesden Patient Participation Group.

Stronger Together

London North West Healthcare NHS
NHS Trust

27th January 2015

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

Director of Operations: Tina Benson
Direct Line: 0208 869 2886
Email: tina.benson@nhs.net

Mr Peter Latham
Chairman Willesden Patient Participation Group
Via email: peter.latham1@btinternet.com

Dear Mr Latham

Please find below from James Walters the information you requested regarding the non-elective marginal rate. For ease of reference I have numbered the questions:-

1. Could you please give us a reference to the current NHS rules governing this sliding scale for A/E remuneration ?

- There is no sliding scale for the payment for A&E attendances. All recorded A&E attendances are paid for at full cost as per national Payment by Results guidelines.
- However, the rules you refer to do apply to emergency in-patient spells, which cross a certain threshold for that particular month. I would direct you to a recent review of the rules that Monitor and NHS England have recently published, which can be accessed via the link below https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300862/Monitor_and_NHS_England_U2019s_review_of_the_marginal_rate_rule.pdf

2. Are the relevant payments made to LNWHT by NHSE or by local CCGs ?

- All A&E attendances are funded by the responsible CCG commissioner. National Health Service England does not commission A&E attendances.

3. Can you tell us what if any modifications were made to the 2009 patient base criterion on Northwick Park Hospital taking on more acute A/E patients on the closure of Central Middlesex and Hammersmith acute A/E departments with effect from 10 September 2014 ?

- The 2008/09 baseline relates to emergency inpatient spells. Any activity above the locally refined baseline is funded at a 30% marginal rate.
- The 2008/09 baseline has been uplifted for the 2014/15 contract year to reflect agreed service developments in emergency care. The baseline will be adjusted once more for the approaching 2015/16 contract, and this will take into account the reduction of emergency admissions at the CMH site.

4. Can you say how much money Northwick Park Hospital will lose for October 2014 as a result of going over the current patient ceiling number ?

- For the month of October the reduction in payment was approximately £220,000 for the emergency spells that exceeded the agreed baseline.

5. What percentage of the revenue for that month does this this amount to ?

- This equates to approximately 1% of all trust wide contract income, and approximately 3.5% of all emergency spell income.

Yours sincerely

Tina Benson
Director of Operations

Stronger Together

London North West Healthcare NHS
NHS Trust

Trust Headquarters
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

Tel. 020 8869 2717

www.lnwh.nhs.uk

18th November 2014

Mr Peter Latham
Chairman Willesden Patient Participation Group
Via email: peter.latham1@btinternet.com

Dear Mr Latham

I am writing in response to your emails of 14th and 16th November 2014 in which you have requested us to respond to questions that you wish to raise at the Brent CCG Health Partner's Forum on Wednesday 19th November 2014. I trust that the following response supports a greater understanding of the situation at both the Northwick Park and Ealing acute sites of London North West Healthcare NHS Trust.

Outlined below is the performance for Accident and Emergency response times for both Ealing Hospital and Northwick Park Hospital. These are for the weeks ending 9th and 16th November; which represent the first two weeks of November 2014. You have requested performance against the national target of 95% which includes specifically type 1 (attendances seen in the accident and emergency department) and type 3 (attendances seen in the urgent care centres linked to the accident and emergency department) patients.

Data showing is for period 3rd November 2014 to 16th November 2014.

Ealing Hospital

The Type 1 and 3 performance was 89.12%

The number of patients for whom we missed the target was 429 at the Accident Emergency and 39 at the Urgent Care Centre.

Northwick Park Hospital

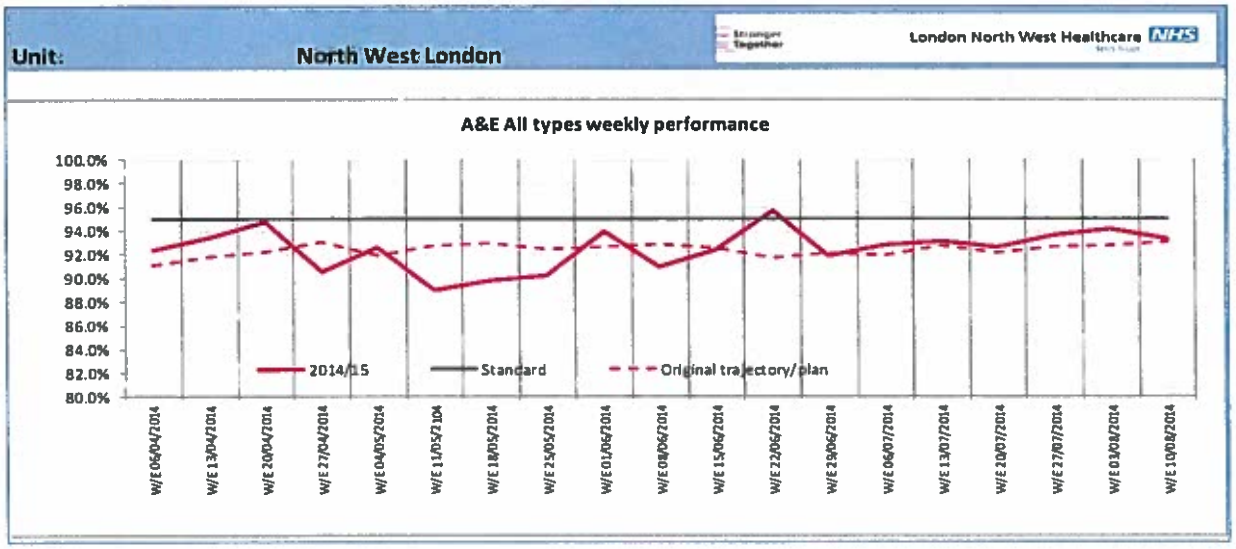
The Type 1 and 3 performance was 83.73%

The number of patients for whom we missed the target was 1139 at the Accident Emergency and 5 at the Urgent Care Centre.

Response to your question on the key bottlenecks

The Trust has undertaken significant amount of investigation supported through the Urgent Care Network Board meetings (now known as System Resilience Group (SRG) to understand key issues both within the Trust and across the local health system. The result of the investigation has highlighted an underlying acute bed capacity shortfall on the Northwick Park site. This is now being addressed with a plan to provide additional bed capacity on the site and is due to be commissioned in late 2015. Up to mid-August 2014

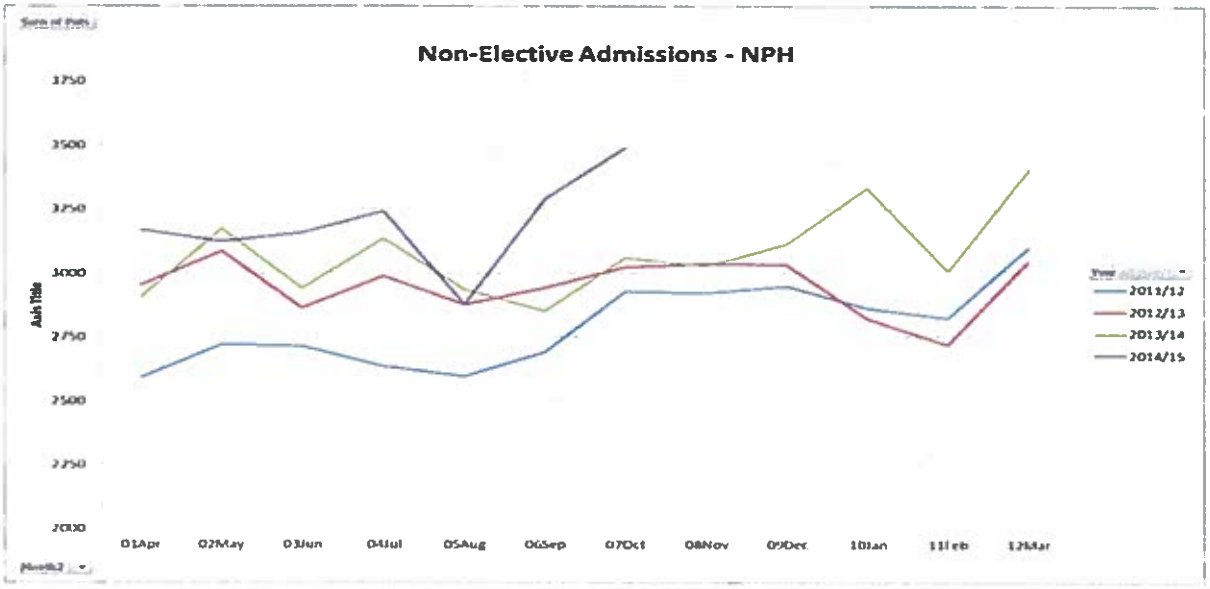
the legacy North West London Hospitals Trust had periods of improved performance which were achieved against the Trust's own trajectory for improving performance.



We have had a steep drop in performance since mid-August 2014 and we are aware that there are a number of key issues that have contributed to this. These are outlined below and to help I have provided the consequence seen in A&E as a result of the problem.

Issue	Effect on Accident and Emergency
Increased Non-Elective admissions	Reduction in available beds – this leads to reduced ability to transfer patients who have been agreed with speciality teams for admission, from the A&E. This in turn leads to loss of capacity to see new arrivals within A&E and increases waiting time for assessment for all patients.
Rising levels of sick patients arriving at Accident and Emergency.	LAS are bringing higher numbers of arrivals using their "blue call" protocol. This requires higher levels of nursing and medical resource to meet the arrival which continues during the patient stay at in Accident and Emergency. These also contribute to the rise in Non-Elective Admissions.
Increase in conversion to admissions from LAS conveyances	LAS conveyances have a higher conversion rate to admission when compared to walk-ins. This puts pressure on the out flow from A&E causing the capacity problems explained above.

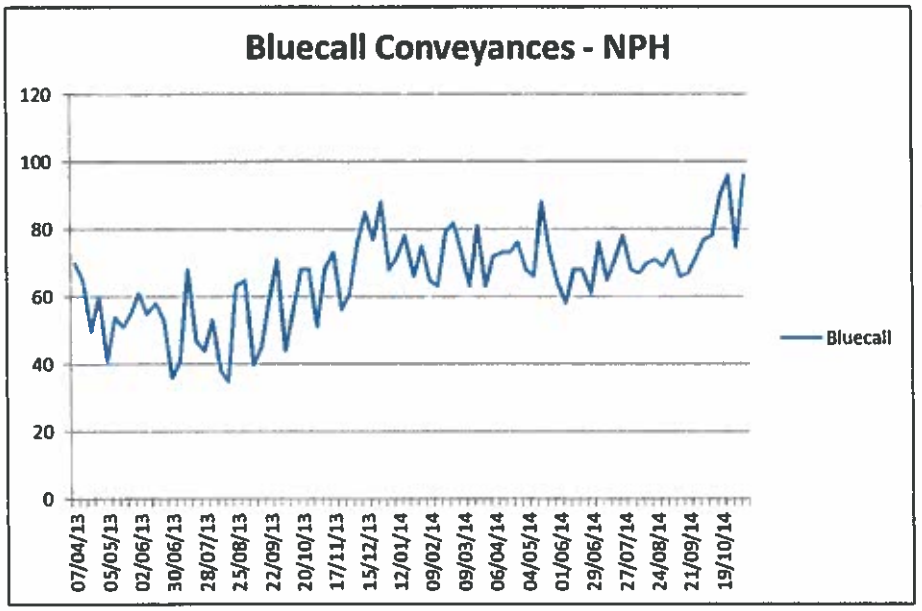
Non-Elective Admissions (NEL) is a term given to all un-planned admissions at a Hospital. They can arrive from a number of different access points, such as a sick patient in Out-patients or after a planned day case procedure, however the main point of entry is via the Accident and Emergency department. The Trust has seen sequential rises in the number of NEL admissions at Northwick Park Hospital over the years, see graph below:



You will note there has been a steep increase in NEL in September and October this year. Upon further investigation this increase started in the middle of August 2014 rather than directly linked to the closure of Central Middlesex and Hammersmith Hospitals. This increase is seen on weekly basis as an average increase from 574 to 620 admissions from the Accident and Emergency department at Northwick Park Hospital each week. Compared to last year this increase is over 400 per month which is approximately 100 per week. We did model what was expected to increase as part of the closure, however the rises seen in the last two months are higher than the modelling predicted.

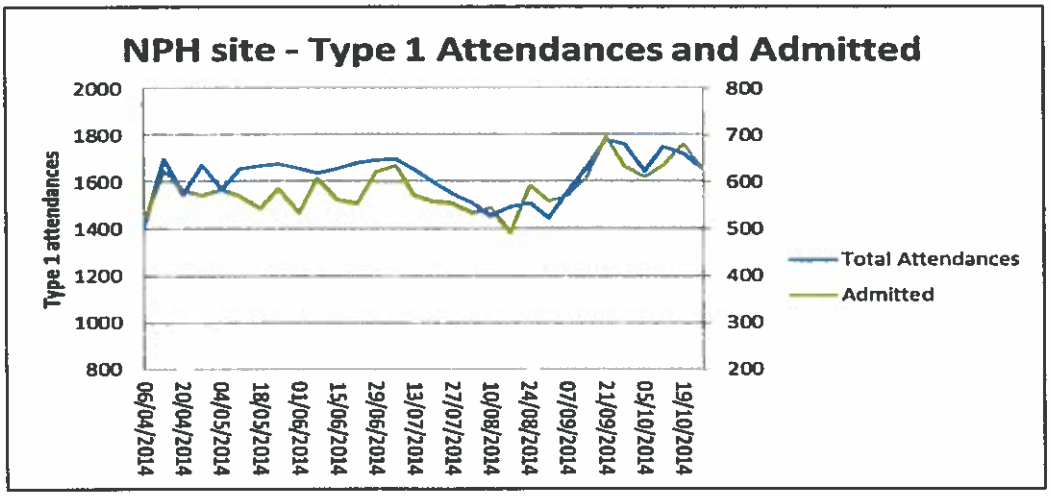
Recent data from the London Ambulance service (LAS) has shown that conveyance numbers to the Northwick Park site have not materially changed since last year. The Trust is in overall agreement with this but there are increases in the peaks and troughs of activity per day which can make some days challenging for an Accident and Emergency department that already has a problem with out-flow and patients waiting for beds in the main ward area of the hospital. We have worked closely with the Shaping a Healthier Future team, which includes colleagues from the Clinical Commissioning Groups, other acute providers in Northwest London and LAS. From the analysis that was initiated by the Trust it was agreed that two key actions would be taken to support the Northwick Park site; i) a change to the processes within LAS where they can support a re-direction of ambulance crews to other less pressured acute sites in North West London and ii) a post-code re-direct; whereby ambulances picking up patients in certain post codes were asked to convey to a specific acute Accident and Emergency Departments rather than Northwick Park Hospital. Both actions do have exemptions to these requests where it has been clinically agreed that changing an ambulance conveyance is not acceptable.

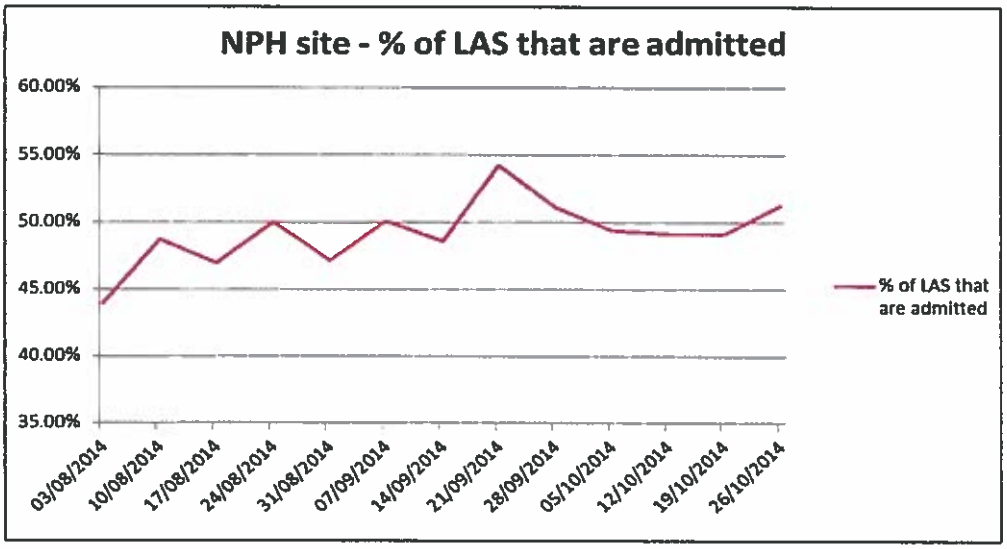
The data also showed that Northwick Park site has had an increase in "blue calls" to the site. Data showing 18 months of activity is shown below:



This rise now means that site is now receiving on average 4 more blue calls per day which is 13 in total per day. Each of these blue calls is phoned through to the Accident and Emergency department ahead of the arrival to enable a response team to be assembled to meet the ambulance on arrival. These cases are initially managed in the resus area of the department which currently has 5 spaces. The management of these cases results in the medical and nursing teams being taken away from other duties within the department. This then causes backlogs in less acute areas of the department, which is particularly noticeable when the Trust receives blue call arrivals in batches.

This rise in acuity of patients is also leading to an increase in conversions from arrivals to admissions. The graph below shows numbers are now higher and that the conversion rate is now 5% higher:





This has the overall effect of increasing the number of patients we have in a bed at any one time at the Northwick Park site which delays the outflow of patients from the Accident and Emergency Department.

The Trust has worked closely with the Clinical Commissioning groups to put in a number of measures to support these increases and to take clear actions to help reduce the pressure at the Northwick Park site. A number of actions have already been taken at this point in time:

1. The Trust, as part of the closure of Central Middlesex, agreed a clinical pathway for specific group of patients who require care beyond their immediate acute phase at Northwick Park Hospital; could be transferred to Central Middlesex under the care of the Elderly Medical Team. This has worked well and the Trust is utilising all of the available beds on that site.

2. The Clinical commissioning groups has supported the Trust with additional community bed capacity. This helps reduce the number of patients who don't require acute care at the Northwick Park site. Beds are used across a number of providers including Hillingdon Hospital (Mt Vernon site), Willesden Community Hospital and a number of other community sites across Brent and Harrow boroughs. Additional community capacity was recently added in the last two weeks.

3. The LAS has supported the site with their Intelligent Conveyancing program which is commissioned by the Clinical Commissioning groups. This helps smooth flows to acute sites who have received a high number of conveyances in a one hour period. Whilst not 24 hours in cover, this has supported a reduction in conveyances to Northwick Park site than if it had not been in place.

4. LAS have also supported with a post-code redirect – patients from specific post-code areas to be taken to other acute A&E departments in North West London – i.e. patients from NW10,NW2, NW6 to be taken to St Mary's Hospital and the Royal Free Hospital, patient with UB postcode to be taken to Ealing Hospital and Hillingdon Hospital. This remains in place and is having positive impact on conveyance numbers to Northwick Park.

Additional Actions

We have agreed with the Clinical Commissioning groups an increased bed capacity at the Northwick Park site. To date the Trust has opened 8 additional beds the week commencing 10th November and a further 8 beds on the 17th November at the Northwick Park site. We are also planning a further increase in mid-December of 10 beds and in February a further 22 beds. These are as a result of bringing forward planned activity and working on how we can further support patients by reducing occupancy at the Trust and improving the outflow of patients from the Accident and Emergency Department.

We have also agreed to reinforce the Intelligent Conveyancing process with LAS to see how they can further support the Trust with the flows of ambulances to the Northwick Park site. Brent Clinical Commissioning Group have also agreed to contact GP practices identified in south Brent area who are still referring patients to Northwick Park where this was expected to shift to other acute providers such as Royal Free Hospital and Imperial Healthcare Trust sites such as Hammersmith Hospital or St Mary's Hospital. These are due to start in November.

We anticipate that these additional actions will reduce the number of patients breaching the 4 hour target by over 120 per week. I would like to stress that these plans will take longer than 1-2 weeks to have an effect; however we are confident that they will support an improvement in the performance of the Northwick Park Accident and Emergency department providing a better environment to care for patients and a reduction in the number of patient's waiting to be admitted in the department each day.

I hope that the above information provides reassurance that the Trust is aware of its under-performance and the key drivers that are affecting recovery.

Regards

Yours sincerely

Simon Crawford
Acting Chief Executive

REPORT FOR HARROW HEALTH & WELLBEING BOARD

UPDATE ON A&E PERFORMANCE AT LONDON NORTH WEST HEALTHCARE NHS TRUST

1. Introduction

This paper provides an update on the Trust's emergency pathway and the actions required to ensure the core A&E performance targets are met.

2. Factors influencing A&E performance

2.1 Ambulance Conveyances

Whilst the overall number of ambulances attending hospitals in North West London has not seen an increase, the number of patients requiring admission to hospital has generally increased. This places additional pressure on the available bed base and can limit patients leaving A&E for a hospital bed as quickly as we would wish. When A&E departments become full, space to see new patients is a challenge and the focus, as you would expect, moves to safely maintaining triage of the most unwell patients.

2.2 Bed capacity

The shortage of beds on the Northwick Park Hospital (NPH) site has been confirmed by an external Demand and Capacity Exercise[1]. The report indicates that in excess of 100 beds are required to address the demand for urgent and emergency services. The Trust has already increased its bed base within the existing infrastructure and submitted a business case to the Department of Health for an additional 63 bedded modular unit that is likely to be in operation around December 2015.

2.3 Workforce

Both Ealing and Northwick Park A&E departments are fortunate to have a stable workforce and relatively low turnover of staff. However due to the number of existing vacant medical posts the Trust is still reliant on the use of regular locum doctors more than they would wish to. It is recognised nationally that A&E departments have struggled to recruit staff; particularly doctors. To address this the Trust has introduced targeted recruitment programs, educational opportunities and other incentives to attract applications.

Northwick Park site A&E was able to increase the number of substantive staff as a result of the consolidation of the CMH A&E staff into the NPH workforce following closure of CMH A&E in September 2014.

[1] Capita report on Demand and Capacity at Northwick Park Hospital – May 2014. This report was jointly commissioned by Brent & Harrow CCGs and the Legacy North West London Hospitals NHS Trust

Workforce and vacancy rates are as follows:

Northwick Park A&E workforce

July 2014	Posts	Recruited	% filled
Consultants	12.9	8.15	63%
Middle & Junior docs	38.29	25.17	66%
Trained nurses	119	94	79%
Untrained nurses	19	19	100%

December 2014	Posts	Recruited	% filled
Consultants	14.4	13.55	94%
Middle & Junior docs	55.79	40.8	73%
Trained nurses	136	116	85%
Untrained nurses	36.37	35.37	97%

As at December 2014 the average total employed workforce is now 87%. A full review of the NPH rota was undertaken to improve the alignment between the peaks in patient arrivals to the department and workforce capacity. This has resulted in Consultants undertaking a 3 month trial of working on-site until midnight, to improve the senior cover in the department, in line with some of our busiest hours (6pm-midnight).

Ealing Hospital A&E workforce

December 2014	Posts	Recruited	% filled
Consultants	7.1	4.1 (plus 2 fixed term locums)	58% (86%)
Middle & Junior docs	23	20	87%
Trained nurses	66.41	61.24	92%
Untrained nurses	9.15	9.15	100%

EH A&E workforce is much smaller. The average total employed workforce is 91%.

At the moment Ealing Hospital (EH) on-site consultant cover is only provided up until 22.00hrs on weekdays and between 08:00hrs and 11:00hrs at weekends (now extended to 14:00hrs). A full review of the EH rota will be undertaken to ensure peaks in the demand for service are covered.

The Trust has in place a consultant on-call system for the out-of-hours periods.

3. Current Performance

Current performance for both A&E departments is below the expected standard. Traditional seasonality appears to have changed and the NHS focus is now on system resilience all year round (not just in winter). It has been noted that there was a drop in performance over the summer months and the Trust has struggled to recover from this.

3.1 Top 3 challenges for Northwick Park A&E:

a. ***Beds*** - a need for in excess of 104 beds to maintain the peaks in emergency demand. The site currently operates at around 98% bed occupancy and length of stay remains fairly constant and at a low average compared to other London Trusts

b. ***Patients requiring admission*** – has increased by 6% against a context of NPH having a large attendance flow to the site relative to the available bed base; NPH handles around 22 A&E attendances per hospital bed per month, compared to a London wide average of 16.

c. ***Blue light ambulance arrivals*** - (category A) have increased by 16% (October 2013 vs October 2014) which is in line with rising admissions and increased acuity of the patients being admitted.

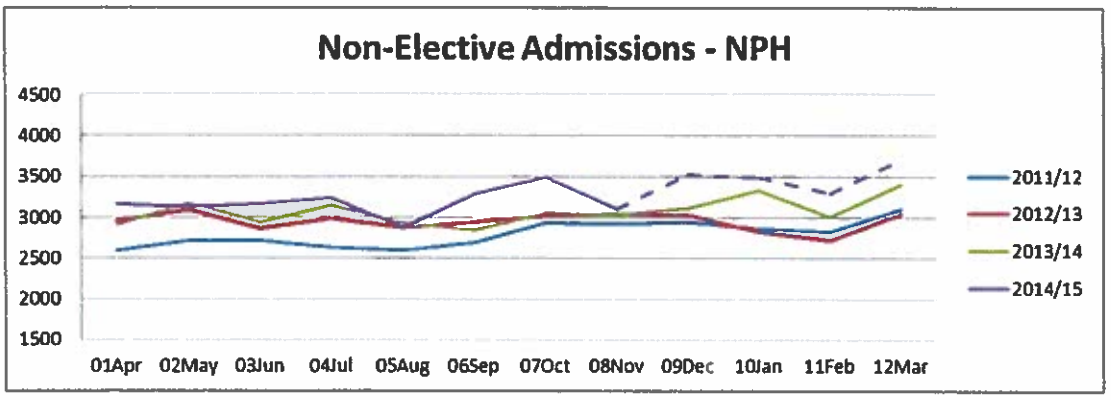
3.2 Top 3 challenges for Ealing Hospital A&E

a. ***Length of stay*** - increased by just under 1 day per patient. This has compressed the bed base available to support the emergency pathway. Some of the additional days are due to delayed transfers of care and some to a 6% rise in blue light (category A) ambulance arrivals

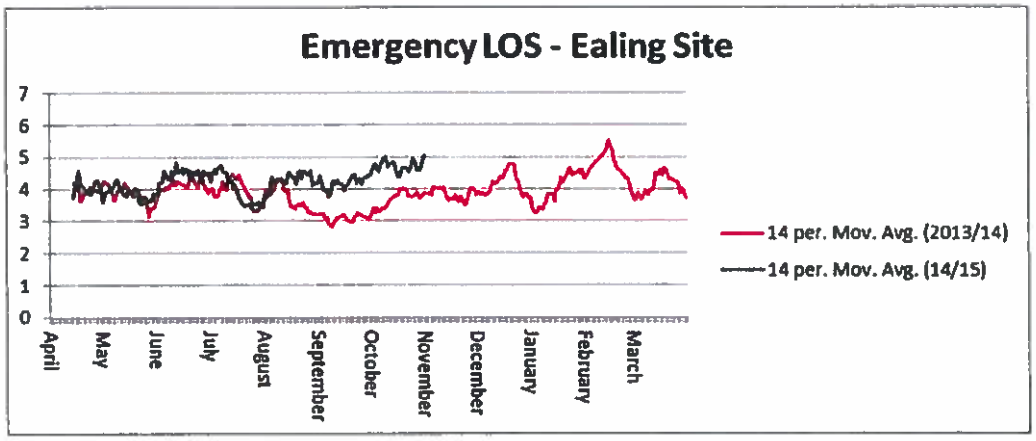
b. ***Beds*** - escalation beds are all open and a further ward is being opened to support demand, bed occupancy has risen from 88% to 98% in recent months

c. ***Staffing & emergency flows*** – staffing levels are considered low and some key staff that support the emergency pathway have been lost as part of the merger.

<u>Increase in emergency admissions at NPH</u>



Increased Emergency Length of Stay at EH



EH has seen an increase in its average length of stay since August 2014. Additional beds have remained open and new ward areas are being made available to support movement through the emergency pathway.

3.3 Current performance against the 95% standard in 4 hours is as follows (December data not yet available).

NPH, EHT & LNWH Weekly AE 95% Performance - Sep, Oct & Nov 2014

	Type 1 Performance (%)			Type 1 & 3 Performance (%)		
Week Ending	NPH	EHT	LNWH*	NPH	EHT	LNWH*
07-Sep-14	73.95%	89.53%		89.07%	94.57%	
14-Sep-14	71.25%	87.85%		87.95%	95.53%	
21-Sep-14	72.82%	83.86%		88.32%	93.43%	
28-Sep-14	74.81%	83.42%		88.95%	93.86%	
05-Oct-14	80.13%	81.32%	80.49%	91.45%	92.22%	91.70%
12-Oct-14	76.47%	81.63%	78.10%	90.05%	92.69%	90.93%
19-Oct-14	69.88%	63.41%	67.85%	87.21%	85.51%	86.63%
26-Oct-14	71.31%	77.87%	73.34%	88.23%	91.98%	89.48%
02-Nov-14	73.01%	77.95%	74.60%	89.24%	91.12%	89.86%
09-Nov-14	66.38%	74.72%	69.16%	86.44%	89.12%	87.34%
16-Nov-14	66.23%	73.83%	68.72%	86.23%	89.13%	87.23%
23-Nov-14	66.74%	78.20%	70.46%	86.39%	91.25%	88.02%
30-Nov-14	62.95%	71.48%	65.75%	84.45%	89.24%	86.10%

4. Actions to improve performance

4.1 Action Plans

The Trust has produced remedial action plans for both A&Es (these reflect the different environment in which the two A&E departments operate in) to address the performance challenges.

EH has traditionally maintained good A&E performance; however the length of stay at that site has been identified as a key challenge. A small average increase of about 1 day per patient is making a critical difference to the sites in-patient bed availability. During peaks in demand this small increase can cause a backlog in the A&E department and impact on the 4 hour performance standard.

The tables below provide an overview of key actions and an update on the on-going work taking place:

NPH Summary Action plan:

THEME	IMMEDIATE ACTION	SHORT-MEDIUM TERM
BEDS	• Carroll Ward 20 beds • Jenner 8 beds • Fletcher Ward 22 beds • Smaller bed changes to incorporate 1 or 2 additional beds within existing wards.	• Modular Wards 63 beds (Dec 15) • Use of old A&E space 4 or more beds • Introduce a Golden Hour Ward Round to help improve weekend discharges and reduce length of stay.
EMERGENCY FLOWS	• Rapid Assessment process to incorporate a senior doctor to take early decisions and reduce unnecessary tests • Ensure a senior doctor reviews decisions to admit if they are to be refused by a speciality clinician for any reason • Place a Medical Registrar in A&E to help co-ordinate admissions to hospital and support the triage and assessment processes • Make best use of the new A&E department to improve triage, assessment and flow.	• Improve resilience, access and turnaround times on diagnostics, such as echo's • Improve transport arrangements to support the A&E department • Update the trust wide escalation plan so that full support is given to the A&E department when it is very busy • Continue to roll out electronic whiteboards that support improved handover and discharge planning • Increase the use of the Ambulatory Care pathways and other direct referral services which can bypass the A&E department where GPs feel it is safe to do so.
WORKFORCE	• Continue to develop new ways of recruiting and retaining a high quality A&E workforce • Maintain & adjust the new A&E rota to support the new department and new	

	ways of working.	

EH Summary Action plan:

THEME	ACTION TAKEN/IN PROGRESS	TIMESCALE
BEDS	• Additional 23 acute escalation beds on 9 North	• Opened November 2014
EMERGENCY FLOWS	• MDT approach for daily discharge planning • Unified Site Practitioner processes	• December 2014 • January 2015
WORKFORCE	• Increased Therapy Support on acute wards and Assessment • Increased senior medical support for assessment areas • Increased phlebotomy staff. • Improve Workforce resilience for managing in competing environment and ensuring safe fill rates for clinical staff	• Ongoing • Recruitment process ongoing – July 2015 • Recruitment ongoing – Jan/Feb 2015 • Ongoing

4.2 Emergency Pathway Taskforce

A task force has been established to improve emergency performance. This consists of the Director of Operations, Deputy Chief Nurse, Clinical Director of the Emergency Pathway and an experienced Project Manager. This group will focus full-time on improving emergency flows and performance.

4.3 Implementation of new patient tracking system

On 5th November 2014 a new patient tracking system 'Symphony; specifically designed for emergency departments was installed. Ealing Hospital already use this system and will ensure improved patient tracking, reporting and governance.

4.4 Opening of new Emergency Department building at the NPH site

After 2 years of building and planning a new emergency department was opened on the Northwick Park site on 10th December 2014. The safe transfer from the old A&E to the new ED was efficiently executed and celebrated as 'well planned' by the London Ambulance Service.

5. Improvement Trajectories

The Trust has agreed challenging improvement trajectories for both its A&E departments. These can be seen on the current performance charts in section 3.3 (above), where they are marked as the green 'estimated' line.

EH has traditionally maintained good A&E performance and it is felt that this can be restored more quickly, predominantly by improving emergency flows and length of stay.

For NPH it is a significant bed increase that will make a big difference and this is not possible until December 2015. Whilst a number of additional beds have been made available at NPH, 63 beds will be added in December 2015 by building a modular unit, containing 3 wards and 63 beds.

The Trust is committed to improving its emergency performance as a key priority and, similar to other London Trusts, is taking all reasonable steps to recover and improve its performance.

Tina Benson
Director of Operations
December 2014

North West London

NHS England

Performance in North West London has been above the rest of London

- Across Q3 the North West London sector was the highest performing for all type A&E performance and therefore above the London average performance for the quarter. Performance at London North West Healthcare was 6.82% above the lowest performing Trust in London across the whole of the third quarter.

	Q3 2014/15 All-type performance	Q3 Admissions 13/14	Q3 Admissions 14/15	Increase in admissions in 2014/15	Q3 Attendances 13/14	Q3 Attendances 14/15	Increase in attendances in 2014/15
North West London Area	92.87%	47,508	47,648	0.29%	307,269	327,683	7.65%
North East London Area	92.01%	72,071	73,446	1.91%	427,310	460,014	6.64%
South London Area	92.27%	68,084	72,859	7.01%	370,368	371,375	0.27%
London	92.34%	187,663	193,953	3.35%	1,104,947	1,159,072	4.90%
England	92.56%						

- Admissions have been broadly flat year on year in North West London area compared to an average rise of 3.35% in London. However, attendances have increased in North West London area by over 123 per day compared to the previous year, with this equating to a 7.65% increase in attendances in Q3 14/15 compared to 13/14. The performance position has been secured despite this increase.

- Length of stay has reduced by 9% at Northwick Park site (Oct 2014 compared to October 2013) meaning that patients are not having to spend as long in hospital and resources are being used more effectively.

- The North West London area had the highest A&E performance of the three London sectors in 10 of the 13 weeks of Quarter 3. There was only one week in quarter 3 where London North West Healthcare had the lowest all type performance in London. The North West London sector has continued to out perform other sectors at the start of Q4.

- Performance at North West London has continued to be well above the lowest performing organisations and provisional performance for 14th January at 89.83%. This was the 11th highest performance out of the 20 trusts that reported.

- For elective care North West London has the lowest number of 52 week waiters across London, is second of the three areas in terms of admitted performance (during this period of backlog clearance) and highest performing against the 62 day cancer standard.

	November RTT 52 week waiters	November RTT admitted performance	Cancer 62 day performance Q2
North West London Area	4	85.60%	83.46%
North East London Area	6	86.80%	79.28%
South London Area	26	83.10%	77.31%
London	36	85.60%	79.20%

…And the clinical model has improved due to the reorganisation of A&E

- The sector now has a more clinically sustainable and safe service, with patients having access to consultant led emergency care and primary care led urgent care in ways not possible before the changes.

- There are:
  - A further 6 A&E consultants at Northwick Park compared to last Winter enabling increased hours of consultant cover to 3 A&E consultants 8am to 10pm and at least 1 consultant up to midnight.
  - Weekend consultant cover at Northwick Park has moved from 9am-5pm to 8am-midnight
  - A further 6 A&E consultants across Imperial Healthcare Trust's A&E sites
  - 6 additional core medical trainees in emergency care at Imperial
  - Additional emergency department flow co-ordinator at Imperial

- Overall the bed numbers for the North West London Sector are up by 39 in 2014 compared to 2013, with Northwick park having an increase of 37 beds.

- All 9 urgent care centres in NW London are now open 24/7. The UCCs at Hammersmith and Central Middlesex are working to the new enhanced UCC model and achieved the 95% target throughout the quarter.

- 291 practices across North West London are now offering evening and weekend appointments which are accessible for 1,729,612 patients

- Delayed Transfers Of Care at North West London Healthcare have reduced from 5.50% of beds being unavailable due to delayed transfers of care in November down to 1.52% on January 14th.

Week Ending	Hospital Trust	Type 1 Departments Major A&E (E)	Type 3 Departments - Other A&E/Minor Injury Unit (G)	Total attendances (H)	Type 1 A&E longer than 4hrs to admit, transfer or discharge (L)	% Type 1 A&E < 4hrs to admit, transfer or discharge	% All A&E <4hrs to admit, transfer or discharge	Emergency Admissions via Type 1 A&E (O)	Number of patients spending >4 hours from decision to admit to admission (U)	England Rating
01/06/14	Ealing Hospital NHS Trust	729	1,259	1,988	26	92.2%	98.4%	346	0	119th Last
29/06/14	Ealing Hospital NHS Trust	767	1,390	2,157	54	93.0%	96.6%	367	0	42nd last
03/08/14	Ealing Hospital NHS Trust	766	1,200	1,966	27	96.5%	98.2%	386	5	98th Last
31/08/14	Ealing Hospital NHS Trust	689	1,197	1,886	24	96.5%	98.1%	364	1	125th last
07/09/14	Ealing Hospital NHS Trust	726	1,207	1,933	76	89.5%	94.6%	386	9	41st Last
14/09/14	Ealing Hospital NHS Trust	716	1,275	1,991	97	87.8%	95.5%	388	19	18th Last
21/09/14	Ealing Hospital NHS Trust	824	1,216	2,040	133	83.9%	93.4%	376	21	11th Last
28/09/14	Ealing Hospital NHS Trust	760	1,309	2,069	126	83.4%	93.9%	336	12	13th Last

Week Ending	Hospital Trust	Type 1 Departments Major A&E (E)	Type 3 Departments - Other A&E/Minor Injury Unit (G)	Total attendances (H)	Type 1 A&E longer than 4hrs to admit, transfer or discharge (L)	% Type 1 A&E < 4hrs to admit, transfer or discharge	% All A&E <4hrs to admit, transfer or discharge	Emergency Admissions via Type 1 A&E (O)	Number of patients spending >4 hours from decision to admit to admission (U)	England Rating
01/06/14	Imperial College Healthcare NHS Trust	2,254	2,417	5,400	132	94.1%	96.6%	714	60	77th Last
29/06/14	Imperial College Healthcare NHS Trust	2,429	2,508	5,754	201	91.7%	95.7%	829	48	34th Last
03/08/14	Imperial College Healthcare NHS Trust	2,121	2,449	5,404	156	92.6%	96.9%	764	64	42nd last
31/08/14	Imperial College Healthcare NHS Trust	2,107	2,467	5,287	188	91.1%	95.2%	690	41	46th Last
07/09/14	Imperial College Healthcare NHS Trust	2,063	2,478	5,371	244	88.2%	95.1%	731	38	30th Last
14/09/14	Imperial College Healthcare NHS Trust	1,978	2,374	5,168	236	88.1%	94.3%	687	61	19th last
21/09/14	Imperial College Healthcare NHS Trust	2,013	2,425	5,218	279	86.1%	93.6%	710	71	14th last
28/09/14	Imperial College Healthcare NHS Trust	1,969	2,418	5,251	192	90.2%	96.0%	669	74	35th Last
05/10/14	Imperial College Healthcare NHS Trust	2,011	2,483	5,285	335	83.3%	93.1%	749	116	10th Last
12/10/14	Imperial College Healthcare NHS Trust	2,062	2,462	5,316	250	87.9%	94.7%	734	68	28th Last
19/10/14	Imperial College Healthcare NHS Trust	2,153	2,446	5,431	376	82.5%	92.1%	720	120	16th Last
26/10/14	Imperial College Healthcare NHS Trust	2,070	2,349	5,228	280	86.5%	94.1%	662	72	29th last
02/11/14	Imperial College Healthcare NHS Trust	2,121	2,383	5,323	310	85.4%	93.2%	631	116	25th last
09/11/14	Imperial College Healthcare NHS Trust	2,035	2,311	5,184	289	85.8%	93.0%	736	98	27th last
16/11/14	Imperial College Healthcare NHS Trust	2,194	2,391	5,388	494	77.5%	90.1%	750	124	9th Last
23/11/14	Imperial College Healthcare NHS Trust	2,152	2,277	5,191	366	83.0%	92.3%	692	199	12th last
30/11/14	Imperial College Healthcare NHS Trust	2,150	2,994	5,941	447	79.2%	90.8%	838	320	8th last
07/12/14	Imperial College Healthcare NHS Trust	2,162	2,337	5,227	525	75.7%	88.3%	697	329	8th last
14/12/14	Imperial College Healthcare NHS Trust	2,298	2,444	5,507	640	72.1%	86.9%	686	398	8th last
21/12/14	Imperial College Healthcare NHS Trust	2,189	2,560	5,465	653	70.2%	86.7%	634	208	7th last
28/12/14	Imperial College Healthcare NHS Trust	2,002	2,079	4,651	414	79.3%	90.8%	592	108	23rd last
04/01/15	Imperial College Healthcare NHS Trust	2,052	2,268	4,988	450	78.1%	90.3%	668	107	60th Last
11/01/15	Imperial College Healthcare NHS Trust	1,989	2,156	4,930	452	77.8%	90.8%	634	141	29th Last
18/01/15	Imperial College Healthcare NHS Trust	2,005	2,065	4,804	456	77.3%	90.2%	590	149	11th Last
25/01/15	Imperial College Healthcare NHS Trust	2,031	2,085	4,817	301	85.2%	93.9%	682	74	37th Last
01/02/15	Imperial College Healthcare NHS Trust	2,056	2,230	5,019	444	79.9%	91.2%	690	108	21st Last
08/02/15	Imperial College Healthcare NHS Trust	1,894	2,222	4,885	293	85.4%	94.0%	639	101	36th Last
15/02/15	Imperial College Healthcare NHS Trust	2,134	2,328	5,191	473	78.9%	90.9%	698	100	27th Last

Week Ending	Hospital Trust	Type 1 Departments Major A&E (E)	Type 3 Departments - Other A&E/Minor Injury Unit (G)	Total attendances (H)	Type 1 A&E longer than 4hrs to admit, transfer or discharge (L)	% Type 1 A&E < 4hrs to admit, transfer or discharge	% All A&E <4hrs to admit, transfer or discharge	Emergency Admissions via Type 1 A&E (O)	Number of patients spending >4 hours from decision to admit to admission (U)	England Rating
01/06/14	London North West Healthcare NHS Trust	1,900	1,726	2,708	117	86.9%	93.9%	674	44	19th last
29/06/14	London North West Healthcare NHS Trust	1,936	2,364	4,300	339	82.5%	91.8%	749	61	6th last
03/08/14	London North West Healthcare NHS Trust	1,723	2,182	3,905	224	87.0%	94.1%	645	58	15th Last
31/08/14	London North West Healthcare NHS Trust	1,728	2,295	4,023	387	77.6%	90.3%	645	120	6th Last
07/09/14	London North West Healthcare NHS Trust	1,790	2,300	4,090	439	75.5%	89.1%	702	143	3rd Last
14/09/14	London North West Healthcare NHS Trust	1,722	2,451	4,173	492	71.4%	87.9%	664	195	3rd Last
21/09/14	London North West Healthcare NHS Trust	1,777	2,420	4,197	483	72.8%	88.3%	704	130	3rd Last
28/09/14	London North West Healthcare NHS Trust	1,751	2,313	4,064	441	74.8%	89.0%	674	141	2nd Last
05/10/14	London North West Healthcare NHS Trust	2,423	3,651	6,074	473	80.5%	91.7%	984	95	8th Last
12/10/14	London North West Healthcare NHS Trust	2,481	3,637	6,118	544	78.1%	91.0%	1,024	149	5th Last
19/10/14	London North West Healthcare NHS Trust	2,570	3,831	6,401	827	67.8%	86.6%	1,041	194	Worst
26/10/14	London North West Healthcare NHS Trust	2,356	3,793	6,149	628	73.3%	89.5%	1,012	179	Worst
02/11/14	London North West Healthcare NHS Trust	2,374	3,847	6,221	603	74.6%	89.9%	991	155	5th Last
09/11/14	London North West Healthcare NHS Trust	2,453	3,705	6,158	755	69.2%	87.3%	928	224	3rd Last
16/11/14	London North West Healthcare NHS Trust	2,599	3,939	6,538	813	68.7%	87.2%	989	209	2nd last
23/11/14	London North West Healthcare NHS Trust	2,583	3,975	6,558	762	70.5%	88.0%	974	237	Worst
30/11/14	London North West Healthcare NHS Trust	2,616	4,103	6,719	896	65.7%	86.1%	1,035	133	Worst
07/12/14	London North West Healthcare NHS Trust	2,623	4,087	6,710	859	67.3%	86.7%	954	132	2nd Last
14/12/14	London North West Healthcare NHS Trust	2,540	4,140	6,680	951	62.6%	85.2%	932	298	Worst
21/12/14	London North West Healthcare NHS Trust	2,626	4,216	6,842	1,216	53.7%	81.4%	922	345	Worst
28/12/14	London North West Healthcare NHS Trust	2,440	3,981	6,421	880	63.9%	85.9%	943	278	2nd Last
04/01/15	London North West Healthcare NHS Trust	2,412	3,811	6,223	900	62.7%	85.4%	936	317	5th Last
11/01/15	London North West Healthcare NHS Trust	2,264	3,391	5,655	871	62.0%	84.6%	871	315	2nd Last
18/01/15	London North West Healthcare NHS Trust	2,269	3,378	5,647	707	68.8%	87.3%	935	300	3rd lLast
25/01/15	London North West Healthcare NHS Trust	2,264	3,474	5,738	620	72.8%	89.2%	974	291	5th Last
01/02/15	London North West Healthcare NHS Trust	2,288	3,720	6,008	677	71.2%	88.7%	941	330	2nd Last
08/02/15	London North West Healthcare NHS Trust	2,326	3,845	6,171	699	69.9%	88.3%	965	289	Worst
15/02/15	London North West Healthcare NHS Trust	2,481	4,033	6,514	689	72.2%	89.2%	1,018	301	6th Last

Smith Peter

From: Rob Sale <rob.sale.rs@googlemail.com>
Sent: 24 February 2015 12:53
To: Smith Peter
Cc: Robert Pinkus; Nigel Davis; fergusmccloghry@nhs.net; Lesley Williams; Jane Betts
Subject: North West London Independent Healthcare Commission
Attachments: 141215-Healthcare-Commission-open-call-for-evidence-letter.pdf

Dear Peter,

Thank you very much for your time this morning.

As I explained we only found out very recently about this Commission. I have written to our Councillors in Harrow expressing our concern that Harrow has not seen fit to sign up with their other 'partners' in the NW London NHS area. The combined impact of the closure/downgrading of acute services, the failure to provide enhanced and out of hospital and community services to offset these reductions, the legacy of the Shaping a Healthier Future experiment, is very significant for people in Harrow, as it is in neighbouring areas. As an umbrella organisation for Patient Participation Groups (PPGs) in the borough we also hear first hand from our members that the pressures on surgery staff in Primary Care - reception, GPs and nursing staff - are massive and this has an inevitable knock on effect on waiting times for appointments with doctors of choice, staff morale and patient care, despite the very considerable personal efforts and commitment of our NHS staff. The extent of the crisis facing surgeries and their patients in Harrow was brought home to us in a recent meeting we had with our local Medical Committee where the picture painted at the coalface is very different from that portrayed in the official literature of the CCG and others. It also appears that the moving over to GP Networks in Primary care is major change in the delivery of Primary care services which is progressing without the degree of consultation and public engagement warranted. I have copied the chair of the Harrow LMC into this email as I am sure they too will be concerned about not being able to have their voice heard by this Commission.

We would very much liked to have given evidence to the Committee which could only have benefited patients in our area. However there simply has not been time for us to prepare and agree a document for today's deadline.

I note that you say you can extend that deadline till the 10th March to allow us more time for which I am very grateful and I will pass this back to our members and hopefully we can get working on it as soon as possible. Perhaps the LMC would likewise wish to take this opportunity should it also be available to them.

I also note that there are 4 public hearings planned for submission of evidence, 3 in March and the last one on May 9th which is in Brent, all on Saturdays. We have recently made contact with our sister organisation in Brent who I understand have made a considerable contribution to the Commission on behalf of their members and I think it would be very worthwhile for us have discussions with them.

Thanks once again for your time.

Robert Sale
Harrow Patients Participation Group Committee

healthwatch
Ealing

Submission to North West London Healthcare Commission

We are writing to inform the Commission of the work of Healthwatch and its predecessor Ealing Local Involvement Network (LINk) has undertaken in relation to informing and engaging the public with Shaping a Healthier Future (SaHF) to influence the design and delivery of the programme for the benefit of patients , their carer's and wider public of Ealing.

From the start we recognised this was a change process that would have huge implications for the people of Ealing in particular. In the light of this,

as LINk and later as Healthwatch, we have sought to make sure the people of Ealing have access to information that will enable them to make their views known to SHaF, Ealing CCG and NHS England.

We sought facilitate involvement at two levels:

1 **Informing and promoting engagement with the SaHF consultation process**

- Published and cascaded any proposals, surveys that came from SaHF,
- Facilitating consultation and dialogue events between the leaders of SHaF and members of the public, for example :-
  - Promoted public to attendance at the SaHF roadshow events 2011-12
  - Active LINk members attended the developing programme planning Boards of the NWL NHS Cluster the early SaHF lead group
  - 2011-13 held a numbers discussion and update meetings between our active members and SaHF leads
  - As Healthwatch we hosted a consultation drop in event in 2012 to enable the public to meet SaHF leads at a one to one level , as well as complete the consultation survey online
  - We hosted public meetings where SaHF, Ealing CCG, Hospital Trusts and LB Ealing leads engaged with members of the public directly through small workshops - Year of Change January 2013, Transforming Services March 2014, to hear and take on board their views on the proposed reconfiguration.

Throughout 2013 to date, we have endeavoured to ensure the public are kept up to date on the SHaF developments and their implications for service delivery and

patient experience and have active members at several of the work groups to ensure the voice of patients are heard and to offer challenge to the programme.

2 Strategic Involvement and co-production

As a statutory public involvement organisation we have had a role being active in ensuring there is public involvement and co-production at the strategic planning the SaHF reconfiguration activities.

After the consultation period and the decision by the Secretary of State approved the SaHF reconfiguration, we were aware as the borough most affected by the reconfiguration of acute services and with need to develop an effective out of hospital services. Our role was to get our active lay members engaged through:

- NWL Healthwatch Chairs and active members being embedded in programme boards and steering groups
- Actively participating in the SAHF Patients Reference Group(PPRG) and time limited work groups reporting to this group
- Members attend the crosscutting Transport Advisory Group(TAG)

As active lay partners our members have taken part in a range of strategic meetings over the last 3 years. They have devoted their time to analysing and challenging business cases and implementation plans, offered solutions from a local and non - professional perspective, to try to get the reconfiguration system to keep the patient and carers needs at the centre of any decision making.

3. A&E Closures

Although only a small number of Ealing residents are directly affected by this change we monitored the implementation through our involvement in the TAG, the PPRG and working with the NWL communications group reviewing their plans for communications and involvement.

3. Ealing Maternity Transition

Members of Healthwatch Ealing have been much more involved in the development of these plans and have been successful in having additional engagement and research undertaken during the early phases of this project. This work led to a remodelling of the numbers of women who would go where.

We have been involved in the communications work stream and have been successful in having copy amended to make it clearer and more accessible. We

have championed more in depth engagement with local women and have been part of the SaHF internal assurance group which has visited all maternity units.

4. Our of Hospital Developments

Healthwatch Ealing is committed to ensuring that the plans around Out of Hospital developments are fully implemented prior to the closing of any services currently delivered in acute settings.

We have been involved in the development of the local Out of Hospital Strategy and our members sit on many commissioning strands. We believe that Out of Hospital plans are developing well in Ealing but we have concerns that the work to develop Health and Well Being hubs will take several years to come to fruition whilst service changes particularly within the new London North West Healthcare Trust might not in the short to medium term bring services closer to the people of Ealing.

Carmel Cahill Chair
Healthwatch Ealing
30th January 2015

Web: www.healthwatchbrent.co.uk
Twitter: https://twitter.com/hwbrent
Email: enquires@healthwatchbrent.co.uk
Tel: 0800 9961 839

healthwatch Brent

Submission to: Independent Healthcare Commission for North West London

From: Healthwatch Brent (HWB)

Date: 24/02/15

Healthwatch Brent (HWB) Summary of evidence regarding Shaping a Healthier Future (SaHF) and A&E in Northwick Park Hospital (NPH) and Central Middlesex Hospital (CMH)

SaHF looked like a well thought through plan – the principle seemed sound regarding balancing needs with costs, concentrating specialist centres in certain hospitals, and the creation or strengthening of community based services. The CCG and SaHF teams came across as thorough and well intentioned.

The sheer amount of papers circulated for SaHF was overwhelming – HWB did not have the capacity to digest much of it at all.

There was much confusion for patients, lay persons, HWB staff and Directors regarding what is part of SaHF, which sub-groups feed into which meeting.

HWB staff and members were constantly confused by the number of changes and who was implementing them – the CCG, NWLHT, NWL Strategy and Transformation Group, NHS England? – and how these related to each other.

In its submission to the Commission, Healthwatch Brent provides snapshots of evidence of this confusion, including meetings attended, emails from members, HWB bulletin reports, and all importantly – concerns expressed by patients. These are table below.

Please also find attached 2 pdf documents relating to surveys of NPH A&E.

Healthwatch Brent welcomes this independent review, and trusts it will provide clarity to many of these complex issues.

Feb. 2015

Table of evidence provided to support Healthwatch Brent Summary	Section / page	Subject
Patient's views of A&E	1a	HWB on-site survey of NPH A&E Dec 2014
	1b	HWB survey of A&E patients Feb 2015
Other relevant patient views gathered by HWB	2	Table of patients' views
Specific issues	3a	NPH
	3b	CMH
	3c	Park Royal Centre for Mental Health and A&E
	3d	Diabetes
	3e	Vision strategy
	3f	WAVE 2 changes
	3g	Rheumatology
	3h	Referral waiting times
	3i	Multiple Sclerosis Nurse
Meetings attended by HWB	4a	SaHF
	4b	NPH and CMH
	4c	Brent CCG
	4d	Heath and Wellbeing Board
	4e	Other documents
	4f	Integration of services
	4g	Closure of CMH A&E project board
	4h	Merger programme
	4i	Confusion
Other	5a	NWLHT financial trouble
	5b	CQC reports on NPH and CMH
		More information is available on http://www.healthwatchbrent.co.uk/content/bulletins August 2014 to Feb 2015

1 **Patient's views of A&E**

1a See 'HWB on-site survey - NPH A&E - Dec 2014' pdf

1b See 'HWB Survey of A & E Patients Feb 2015' pdf

2 **Table of patients' views**

Source / subject area	**Nature of view** Where comments were received via enquiries, the person was referred to complaints or signposted to relevant service.
Some issues that came up in talking to **people with learning disabilities**	It took a long time to get home from CMH – had to wait a long time We need specialist services but we need help to get there.
Discharge from hospital	The person who the CI cares for is being discharged into the community – not sure how this works
Access to services	Client's mother wants to be able to get NHS treatment – not sure how to
Legal advice	I have advocacy from Voiceability but I need legal representation
Compliments	CI wanted to know how to praise CMH for her procedure
	CI wanted to know about the provision of podiatry services in residential homes in Brent.
	Called the Emergency Control Room and had to wait 2 and a half hours before an ambulance came.
	i live in the brent part of cricklewood and have been told by a neighbour that central middx offer special treatment for patients with bronchial problems. this includes exercise therapy, he said. i would love to know more about this unit as i suffer quite a lot from severe breathlessness.

Complaints	
Complaints Hospitals	CI wishes to make a complaint about NHS treatment she has received
	CI wishes to complain about mother's death in hospital
	CI wishes to complain about way CMH treated family
	CI wanted help to register a complaint against his GP and hospital
	Complaint about a procedure at Central Middlesex Hospital
	CI is unhappy with the response he got from Northwick Park Hospital
	Request for females to be present whilst under general anaesthetic was ignored
	Waiting a long time for results about my eyes (CMH?) CI wanted to lodge a complaint against NHS for negligence.
	I need help on how to make a complaint with one of the NHS service in Brent Please let me know if you will be able to help me
	CI wished to complain about hospital treatment she received at NWPH in the Oral and Maxillofacial Dept
	The CI is suffering from a disability which has happened as the result of a mistake during surgery at Royal National Orthopaedic Hospital, Stanmore
	CI has a problem with Northwick Park Hospital. He has already written to the Chief Executive to complain and is not satisfied with the reply.
	The CI wanted to know what is available for her son who is an adult having mental health problems.
	Called out of hours crisis team (NHS) about anxiety. (A tenant in my house - NB supported Living – was flipping out) The person didn't have a clue and said: 'Can't giver confidential

	information to help that person'
	Not getting the service my son needs from Brent Community Recovery Team at Brondesbury Road.
Mental Health services in hospitals	When someone is admitted to hospital with a physical and a mental health issue, the physical condition is treated first. Staffs seem to lose respect for mental health issue. It can be over an hour before anyone attends to the mental health issues Lack of understanding of people with autism and staffs generally do not deal with the cases effectively. The service is too rigid. Lack of respect for confidentiality at A&E, Northwick Park Hospital. Better training of all staff, because so much more is expected of them Staff need not be so defensive. They need to admit when it is not their specialty and to get the appropriate person involved. There needs to be a named person allocated to the person in hospital, who is the person responsible, and who can be consulted with for information. Staffs need to listen to support workers to get the background of the person admitted.
Community Services Wembley Centre for Health and Care	
Diabetic services	Very satisfied with diabetic nurse service at Wembley Centre for Health and Care The diabetic nurse is not punctual, I had to wait at least half an hour.
Breast screening unit	Very satisified with service. Pleased to receive an automatic reminder as unlikely to remember to book an the appointment every 2 yrs as there is cancer in the family Very good service

Health visiting service	Received very good support and takes care of baby Very satisfied with the service
Blood tests at Wembley Centre for health and Care	Very happy with the service. Very satisfied with pharmacy delivery of medication.
Dermatologist	Need to answer phone, only voice mail. Need to make 2 appointments. Don't get hold of them"

Hospital Podiatry	Complaint	"No receptionist was at the desk to welcome and acknowledge that I had arrived. On the desk was a notice to take a seat and wait to be seen. When I try to phone in there is no one to answer the phone. There should be a friendly face at the desk to greet patients and to take messages".
Physiotherapy	Complaint	Physiotherapy for baby. "I felt the service could have been more friendly. The physiotherapist did not read the notes beforehand. I had to explain everything. It would have been better if the physio had prepared to deal with my baby who has many health problems. I felt that i was given the run around from Brompton hospital to here."
Podiatry	Complaint	"Long time waiting for a appointment"
Medical Centre Physiotherapy	Complaint	Appointment time "Waiting time is too long. I was in a lot of pain and was given 10 days to wait. I asked for a cancellation to fir me in. Fortunately I waited 3 days." "We protested against the closure of the Medical Centre on Willesden Hg Rd. Things have settled down for now".
Hospital	Comment	"Stop closing the A&E at Central Middlesex"
Maternity services	Comment	Scan for pregnancy. "Not happy with male Dr. He pressed me too hard. I felt that he was confused. He did not explain things clearly".

Hospital	Complaint	"Waiting time, need to wait for 1 hour"
Hospital	Comment	"Would have liked someone to say how long we had to wait, was seen after 30 minutes."
Accident and emergency care	Complaint	"Waiting tine at hospital is too long. To see the doctor had to wait 45 minutes."
Children & young people's health services	Comment	"Better understanding about autism in children. Staff should have special training or see him first. Waiting is frustrating for the child."
Maternity services	Compliment	"Quite satisfied about services"
Hospital	Compliment	"I wish the A&E would stay open"
Hospital	Compliment	"Very satisfied with the staff and service"
Maternity services	Compliment	"Not had to wait long for emergency with a child. Nice doctor"
Hospital	Compliment	"Good. Pleased with service"
Hospital	Compliment	"Was good. Friendly Doctor, made me feel at ease." Involving Dr Manning
Hospital	Compliment	"Very good, pleased."
Hospital	Complaint	The Cl had a procedure on 31/8/2010 and because it was done wrong subsequently had to have 4 revisional procedures. The last procedurte was on 31/8/2011. The Cl put her case in the hands of a 'No Win No Fee' solicitor because she was told that she could get more than the £4,000 compensation offered by the surgeon. However, the Cl regards her as incompetent. As an example, the Cl rang her solicitor to find out about progress but was told that she waiting for all the Cl's records. When the Cl rang the GPs they said that they had never even heard from

		the Cl's solicitor. Further they said that they usually respond within 24 hrs. When challenged the Cl's solicitor said that she had other cases to deal with. The Cl's solicitor has now closed the case. The Cl went to the Legal Ombudsman to complain. Unfortunately, the Cl has no confidence in him either. After 2 months he is still waiting for papers from the Cl's former solicitor. He said that it would take up to 3 months. The Cl rang him to check progress because she only has one more month before she has to present her case in court. The Cl asked whether she is eligible for legal aid but checking on www.gov.uk it does not look like her problem qualifies. The nearest is 'clinical negligence (only if your child has been severely injured during birth or in the first 8 weeks of life)'.
		The length of waiting time for appointments to see Dr Levin at Central Middlesex Hospital
Hospital	Complaint	"The appointment needs to be shorter

Health visiting service	Complaint	Complaint about Chalkhill Community Centre,health visiting service for baby. " Because I was sick I missed my appointment with the health visitor when my baby was 3mths old. I couldn't have an appointment for him until he became 7mths. The appointment should have been quicker because babies need to be seen."
GP Services	Complaint	Complaint about the inefficiency of the referral system between Park Road surgery and the eye department at Central Middlesex hospital. "I've been getting a run around from my GP surgery and CMH. I had my annual eye check and was given new glasses. There was I problem with one eye and the Optician gave me a letter to give to my GP. I needed to have my eyes examined at Central Middlesex hospital. I have been waiting a very long time to get the appointment. When I checked at my GP surgery the receptionist said that the referral letter was faxed to the hospital. I went to CMH but they said that they had not received the referral. The GP receptionist claimed that CMH had lost the referral and they would fax it again . I'm going back to CMH to follow this up. In the meal while I'm feeling something like gravel in my eye and cobwebs in front of my eye. This is very distressing for me"

		Complaint against RNOH, Stanmore
Hospital	Complaint	Cl's 14 yr old daughter, Fatima, has been disabled from birth. Fatima is in receipt of DLA - care component: highest rate and mobility component: high rate. She is confined to an electric wheelchair. The Cl is in receipt of Carer's allowance for her. In 2009 Fatima was diagnosed as having a dislocated hip but the Cl was not told. In 2010 and 2011 Fatima suffered from pain in the hip. She was given a botox injection to relax a leg muscle. This was deemed sufficient because she is sitting all the time. She was still suffering from pain. In 01/2012 Fatima had a procedure which involved reducing the length of one leg by 4cm. This did not reduce the pain. Fatima has been told that she cannot have a hip replacement operation until she is 18. Until then she has to have steroid injections every 4 months under a general anaesthetic to relieve the pain. The Cl wished to lodge a complaint against the NHS because she discovered that had Fatima had an operation on her hip in 2010 it would have been easier and she would not have had to have her leg reduced by 4cm. Secondly, since she had the procedure in 01/2012 she has developed arthritis. This would not have happened had she had the operation in 2010.
GP Services	Concern	GP taking time to get results back for urine test and blood test. Referred to hospital and had to repeat tests.
Hospital	Concern	Access by public transport from Harlesden to Northwick Park Hospital.

Ambulance or patient transport	Complaint	4 hour wait for an ambulance last Friday 29/8/2014 in Willesden. Blood clot on lung - life threatening.
		IAPT: Good: Counsellors very good
Mental health	Complaint	Needs to be better: Took ages waiting to be seen. Paperwork a shambles.
		Dear Charles Morris, Thanks for forwarding my earlier question, I have a further question not directly related to mental health. I do not recall having seen any comments from either Brent or Ealing Healthwatch on the merger between Ealing Hospital Trust and the North West London Hospitals NHS Trust. My impression is that the concept behind the NHS and Community Care Act was to break down the old regions and to provide for a more responsive local service. How will this merger improve local services?
Accident and emergency care	Questions	

Hospital	Questions	Up to now Ealing and Brent Healthwatch organisations have operated as separate entities but given the merger of the Ealing and the Northwick Park Hospital Trusts will this not create a problem in monitoring services across borough boundaries and would not a merger of the Health teams be more effective?
Community health services	Concern	On 17/10/2014 a member of the Reablement Team, Brent Adult Social Services - Assessment Support, Brent Civic Centre came to see the CI for an assessment.
Children & young people's health services	Compliment	We get to share our opinions and they through. It involves a psychiatrist and a support worker.
Children & young people's health services	Concern	The CI felt that the meetings were consistent. However, they needed to be more empathetic and with less judgemental therapists. This involves a psychotherapist.

		Re: Central Middlesex Hospital
Hospital	Complaint	"There are communication problems, mostly with admin staff. They need to be more efficient. I ran up to make an appointment, I gave my name and address and I was told that I had been discharged because the records shows that I had died" "Another time I was kept in A&E for 10hrs, without a diagnosis. I felt dreadful. I later found out that I have an over active thyroid- I don't have any faith in the medical service".

<u>Presentation re elective orthopaedic centre 8/7/14</u>

Questions from patients

Who will people be referred to?

Is it part of CMH?

What is the difference between [the services] now and the future?

Transport – people who are not near to the hospital and/or have no access to public transport, they have to have someone with them. How do you decide who gets transport and who doesn't? What happens if someone needs a carer?

Someone might have to go to St Mary's or NWP. For me that's far away. Many people need local services. It takes a long time. Many buses or trains.

When A&E closes at CMH we'll have to go to NWP. There are no arrangements with bus companies for that.

Would waiting times be improved so you don't have to wait so long for an operation?

With the amount of cuts going on how do I know this is not going to affect the new model?

Some hospitals are dirty, how do I know they don't catch MRSI?

14 out of 16 people want written as well as verbal information

Most people want to see a physio close to home or at the GP's rather than visit hospital

Care co-ordinator is a good idea. Would like to see / speak to the same person each time. They should be qualified (medically) to do the job.

Brent doesn't have enough home help when you come out of hospital to help with cleaning and jobs around the house.

Waiting 6 weeks for aftercare at the moment is too long when you get out of hospital there are 6 or 12 months waiting lists at the moment and operations go wrong

A hospital in Yorkshire got a chef in to improve the food

Everyone want s a surgeon/consultant to see them after the operation – they can tell if something went right or wrong. I want them to be honest.

END

Regarding hospitals

The waiting time for rheumatology appointments at Central Middlesex is too long – there is only one specialist doctor.

Out of hours service difficult to access for learning disability group as less staff present.

Need more time to consider options for treatment as well as risks and benefits. If we have concerns afterwards often told we were told/warned.

A carer from a Bengali background was not given enough information to understand the hospital procedures after her husband was admitted. Consequently she worried about the decisions that were being made and whether they were for convenience or in her husband's best interests. She found if difficult to assert her views.

From HWB bulletin

Issues and concerns

Healthwatch Brent gathers views and concerns about local health and social care issues, so that we can help make them heard.

Issue raised May 2013:

Northwick Park Hospital

- Accident and Emergency - waiting times too long
- Discharge of older patients too slow ('bed blocking")
- Delays in getting results from blood samples

The introduction of the new **NHS 111** free number for patients with urgent, but not life-threatening symptoms, designed to replace the NHS Direct advice line and out-of-hours GP call centres has been fraught with difficulties. It is probable that more people are being sent to the already overstretched Accident and Emergency services as a result of the telephone consultations.

Giving information

HWB also gives information to its members and on its website

In April 2013 HWB sent out the following links. We are unclear how this guidance impacts on informs local commissioning

3 **Specific issues**

3a NPH

3b CMH

3c Park Royal Centre for Mental Health and A&E

3d Diabetes

1. **Statutory guidance published on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies**

http://healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

June 2013

- There has been a decline in the service for people with diabetes, even though the number of people with diabetes is increasing.

Response:

There have been no commissioned changes to the diabetes services in Central Middlesex Hospital.

Further information needed:
Please let Brent Healthwatch know how the service for people with diabetes has declined.

- There is not enough attention given to patient engagement and consultation, including the Patient Participation Groups, the lack of engagement prior to consultations and the public inclusion in the CCG governing body meetings – particularly the need for better access to the paperwork and retaining 30 minutes for the public to ask questions prior to the meeting.

Response:
"NHS Brent is committed to the development of patient and service user groups as a part of improving commissioning, improving delivery, reducing health inequalities and improving self care. We would like to look at ways in which we support the development of these groups but this development must be aligned to our core objective to improve the health and well being of the population of Brent in a way that allows us to maximise the benefits of the investment of time and resources. Would it be possible to find out more about your intentions for this?"

3e Vision strategy

July 2013

Vision Strategy

The CCG are looking to tender out ophthalmology services in near future and there was a discussion about it at the Health scrutiny and overview committee recently.

The Thomas Pocklington Trust is working with Brent Association of the Blind to develop a Vision Strategy for Brent, based on the aims of the UK Vision Strategy.

They would like to invite you to attend an introductory meeting to discuss what they are trying to achieve and how they hope you can become involved. For clarity, Pocklington is not seeking funding or to bid for services as part of this work. Further detail of the work can be found at: www.pocklington-trust.org.uk/Empowerment/vision+strategies.

26 September from 11am to 1pm at the Bridge Park Community Leisure Centre, Harrow Road, NW10 0RG. Lunch will be provided. A full agenda will be provided soon.

The Thomas Pocklington Trust says: "In Brent there are 2,310 people registered blind or partially sighted with potentially 10,000 or more unregistered individuals living with sight loss in the borough. Working with partners in Brent, we want to look at how the needs of these individuals can be best served whilst improving efficiencies (£13.21 million was spent on problems of vision in 2010/11 in Brent). We know that there are good practices within Brent and we want to bring people together to build on this and to identify where further improvements can be made based upon best practice case studies and models from across the country. Naturally this would link to other health and social priorities such as diabetes, obesity, falls prevention, smoking, learning disability, social isolation and depression amongst others."

HWB does not know if this issue was followed through with action and outcomes, but Middlesex Association of the Blind should know.

3f WAVE 2 changes

2. Commissioning high-quality care for people with long-term conditions

This report highlights the findings of an in-depth study of commissioning. Effective commissioning is a core priority of the coalition Government's reforms to the NHS in England. There has been extensive research into the effects of commissioning over the last two decades, but little analysis of what commissioners actually do.

The Nuffield Trust was funded by the National Institute for Health Research Health Services and Delivery Research (NIHR HS&DR) Programme to conduct a two year study of commissioning practice in three high-performing primary care trust (PCT) areas (Calderdale, Somerset and the Wirral).

http://www.nuffieldtrust.org.uk/publications/commissioning-high-quality-care-people-long-term-conditions

Wave 2 Planned Care Stakeholder Engagement Groups for Musculoskeletal (MSK) and Gynaecology services

There are 2 separate stakeholder groups, one for the gynaecology and one for the MSK workstream. HealthwatchBrent asked the CCG who is on these stakeholder group, how were the members decided upon and how will their interest in shaping health services be taken forward if they are not in the group(s)?

Jatinder S. Garcha, Brent CCG's Wave2 procurement lead, sent this reply:
"... All nominations that came forward within the requested timescale have been included on the groups. For anyone that has not managed to join the group there are a number of ways that they can keep up to date with progress and provide their view.

The two key channels include specific web pages set up on the NHS Brent CCG website, which host all publicly available documents in relation to the Wave 2 Planned Care Programme, and a public consultation process that commenced on Friday 4th April and will run until 30th May. The consultation process is the first of two stages of consultation."

See page 4 of this bulletin for more information or go to the Kilburn PPG meeting (see under 'events')

Re: Review of gynaecological and musculoskeletal services in Brent - request for phone interview
Peter Latham peter.latham1@btinternet.com
Tue 25/11/2014 17:22
To: cleo.heath-brook@mottmac.com
CC: Ian Niven [HWB]
25 November 2014

Dear Clea and Sophie,

Review of gynaecological and musculoskeletal services in Brent - request for phone interview

On 5 November 2014 I was requested by the e.mail below from Brent Healthwatch to take part in a telephone interview for the Mott MacDonald Impact Assessment for NHS Brent CCG 'Shaping a Healthier Future' Wave 2 MSK project I replied the same day in the copy e.mail below agreeing to take part. I have heard no more.

Today I learnt from a PPG colleague Councillor Keith Perrin that he had been requested by Cleo Heath-Brook of Mott MacDonald to take part in such a telephone interview for this project.

Could you please let me know what has happened about the invitation for me to take part ? I am the Chairman of Brent CCG Willesden locality PPG group.

Kind regards, Peter Latham.

Brent Clinical Commissioning Group [CCG]

Consultation on outpatient services (Wave 2 Planned Care)
The CCG is asking for views about its plans to improve the provision of the following outpatient services for people in Brent:

Orthopaedics - Physiotherapy - Rheumatology (MSK) - Gynaecology
Brent CCG says that currently a lot of outpatient care is delivered in hospitals. One of its priorities is to move more outpatient services into community settings. They think this will help to provide care for residents which is:

- Accessible, both in terms of location and availability
- Safe, consistent and high quality
- Integrated, whereby groups of services are brought together in one place
- Centred around the patient's experience, reducing unnecessary delays

Click here for more information and the questionnaire: http://www.brentccg.nhs.uk/en/your-opinions-matter/current-ccg-engagement-and-consultation-programmes You can ask for a consultation booklet by email (cleo.heath-brook@mottmac.com) or telephone (0207 651 0540) or go along to one of e CCG's public roadshows (Website: www.brentccg.nhs.uk/wave-2-MSK). **Deadline is 30th May. [2014]**

3g Rheumatology

Working together

"I am a Carer of a rheumatology patient, and extremely concerned about the many defects in the consultations being carried out by the CCG, and the potential loss of the service as a result of the tendering out. My principal concern is that the Northwick Park arthritis centre is a specialist centre with much research and training, and acknowledged by NHS England as a specialist centre and I do not intend for my husband to be treated other than by the experts who've managed to get his condition under control."

Of our 117 members, some of the most active have raised concerns about a lack of consultation on proposed changes to hospital services, and made complaints about NHS services being re-tendered without the correct process being followed. This included a complaint to Monitor who demanded a response from Brent CCG.

3h Referral waiting times

Northwest London Hospitals (NWLH)

NWLH Report into 18 Weeks Waiting Times

Northwest London Hospitals commissioned an external review to find out why some patients had to wait more than 18 weeks for a referral to treatment. The review panel has now completed their report.

These are the main findings:
'While it is important to recognise the distress and discomfort that may have been caused to patients who were left waiting longer than 18 weeks for their treatment, the panel were satisfied that no significant harm came to any patients and no patient died as a result (page 3 of the report).

The panel were content that the Trust has fully identified the causes of the 18 week delays and that appropriate action has been taken to address these causes. However it is essential that the Trust continues to maintain its focus on further improvements in 2014 and beyond (page 4 of the report).

The panel have given recommendations for how the Trust can regularly audit its performance to ensure that the new processes are successful in preventing any further problems (page 4 of the report).'

You can find the full report here: www.nwlh.nhs.uk/about_us/Agenda-and-papers/

For any comments or questions please feel free to contact the office of David McVittie, Chief Executive and Merger Transaction Director, on 020 8869 2005.

3i Multiple Sclerosis Nurse

Reduction of local and community services –

Multiple Sclerosis (MS) nurse

It has come to our attention that the contract for the MS nurse for Brent may not be renewed resulting in the termination of this much needed service. There is no information regarding community services for people struggling to get on with life with MS on either the website for Brent CCG or the Ealing Integrated Care Organisation (ICO), which provides community services, apart from referring to the MS Society, a voluntary organisation.

If there is no replacement, people will be asked to see their GP instead or will have to travel to en al L nd n s i als S Ma y's, Na i nal H s i al f Ne l y and Ne s e y (UCL) and Charing Cross. Some may go to Central Middlesex or Northwick Park Hospital to see a consultant. There would be no specialist local service.

In this short film Donna Holmes explains what it can be like to loose an MS Specialist Nurse: http://www.youtube.com/watch?v=mJhQVqwM6C8&feature=youtu.be&hd=1
This was published as a f e MS S ie y's Stop the MS Lottery Campaign in May this year.

The MS Society published a recent survey: My MS, My Needs http://mslottery.mssociety.org.uk/ There is some evidence that in November 2012, people from Ealing had better access to MS Nurses and community rehab services than Brent.

Healthwatch Brent is currently looking into this issue and we are hoping to get an answer soon from the newly appointed Assistant Director South: Localities and Out of Hospital Lead, Isha Coombes.

Jan 2014

Update on MS (Multiple Sclerosis) nurse for Brent Isha Coombes, Assistant Director , Out of Hospital & Southern Localities, Brent CCG, replied to our enquiry about the provision of an MS nurse for Brent:

'We recognised the valuable support that the nurse provided for patients, their families and carer's. Therefore we are having on-going discussions with the provider to consider how best to develop this role on a permanent basis as part of our wider development of integrated nursing teams. We aim to have reached a decision by the end of March [2014].'

April 2014

Update on Multiple Sclerosis (MS) Nurse (see also previous bulletins):
We had the following reply from Isha Coombes: 'The CCG is has identified funds to invest in developing integrated nursing teams and we are currently in the exploratory phase of working with clinical teams to develop this further. The initial feedback from clinicians is that investment is better utilised in employing neuro-rehab nurses - which allows greater flexibility of managing neurological problems.

There is a workshop provisionally booked for early May to progress this work stream

4 Meetings attended by HWB

4a SaHF

Dec 2013 HWB bulletin –

Shaping a Healthier Future (SaHF)

SaHF sets out a vision for the development of health services in Northwest London. Healthwatch Brent directors attended a positive and informative meeting on SaHF. Brent CCG provided an update explaining that they are engaging with the public. They outlined

proposals for Central Middlesex Hospital (CMH) and its implications for Willesden Centre for Health and Ca e (WCHC) They want to hear people's views.

There was general agreement that option 2, creating a Hub Plus for Brent at CMH, was worth looking at. This means it would house primary and community care services, GPs, an urgent care centre, outpatients, diagnostics and intermediate care and might also include an elective orthopaedic centre, specialist rehabilitation services, relocation of mental health services and the regional genetics service.

There followed a discussion about the effect this option would have on WCHC. Find out more about SaHF here: http://www.healthiernorthwestlondon.nhs.uk/

NHS Brent CCG - Commissioning local health services

The CCG is working to its Out of Hospital - Better Care Closer to Home strategy. This strategy looks at health services that can be offered away from traditional local hospital buildings and acute provider settings and be available locally for patients and prove more cost effective.

The aim is to develop consistently good services in the community and focus on self-care, early diagnosis and high quality management of long term conditions. Ambulatory emergency conditions will also be treated in the community when appropriate. These are conditions that are not urgent or life threatening but need further investigations. This would enable acute hospitals to focus on patients who are critically ill and those who require specialist investigations and interventions.

11 specialities have been identified for which it is considered appropriate and safe to deliver care out of a hospital setting. These specialities are being assessed for the opportunity to commission more innovative models of outpatient care in Waves.

- Wave 1 was for cardiology services (medical speciality dealing with disorders of the heart) and ophthalmology services (medical specialism in the treatment of the eyes) and new contracts have been awarded for these services.

- Wave 2 is underway and is for musculoskeletal - or MSK - services (medical specialism in the support, stability and movement to the body) and gynaecology services (medical practice dealing with the health of the female reproductive system). MSK services include rheumatology, trauma and orthopaedics and physiotherapy and will cover outpatient care only (that is cases that do not require overnight stays).

Future waves will consider paediatrics, gastroenterology, clinical haematology, dermatology, general surgery, ENT, urology and medical oncology.

The tender process for Wave 2 will include an impact assessment and a first meeting was held on 17th December to consider what this means and what it will involve. Some of the concerns raised were:

- The CCG had not provided enough background information for people to make informed comments (eg about current provision, demand and demographics);
- The reallocation of resources would result in the reduction of acute services, such as at Central Middlesex Hospital;
- There would be less consultants and continuity of care for long-term patients;
- There would be confusion about which service a patient could access;
- Smaller local providers are disadvantaged in the tender process as they do not have the finance for capital equipment and venues or tender expertise, even when patients are content with the provision;
- Local provision is less of a factor for most patients than quality of provision.

You can contact Mott MacDonald, the company commissioned to undertake the Impact Assessment, by emailing sarah.mcauley@mottmac.com or telephoning 0121 234 1596.

4b NPH and CMH

Meetings about the Future of Willesden Centre for Health and Care and Changes at Central Middlesex Hospital (CMH)

(12th December 2013 and 14th January 2014)

There was an initial meeting in Brent on 12 December which looked at the options for Willesden Centre for Health and Care if some services moved from there to Central Middlesex. People there - including patient representatives - heard about the options and agreed to attend another bigger meeting on 14 January 2014. This meeting was held at Central Middlesex Hospital.

Under the Shaping a Healthier Future plans, only 35% of CMH's capacity would be used, leaving a big and expensive space to fill (or dispose of)

In between the meetings NHS people had done more work to evaluate the different options. The aim was to look at what "bundles of services" could utilise the space at Central Middlesex. Each bundle was then checked against criteria such as Quality of Care, Access to Care, Affordability and Value for Money, Deliverability and research and Education. There was long presentation explaining exactly how that was done and the results. We had the chance to ask plenty of questions We then had to look at the 4 different possible options in Groups and discuss the preferred options. Each group had a mix of NHS and patient representatives. The general feeling was the

preferred options were 1a or 1c. Option 1a was the CMH bundle plus Willesden Bundle, Option 1c was the CMH bundle plus Willesden partial Disposal. No one wanted the disposal of CMH or Willesden sites which were the other options. There is still a lot of work to be done before final decisions such as

- will all NHS local partners agree how much finance they can put in,
- will proposed services be willing to move,
- will the Private Finance Initiative partner at Willesden be willing to allow some of the building to be changed.

This is a very simple summary of a very complicated issue. It is fair to say that the patient reps and Healthwatch Brent Reps who were there felt that the options had been looked into and explained, that the suggested options seem sensible and that our questions and comments were answered and taken seriously.
You can find out more here http://www.healthiernorthwestlondon.nhs.uk/news
Ann O'Neill Healthwatch Brent Interim Co-ordinator

April 2014

Shaping a Healthier Future (SHAF) Implementation Update:
We had a presentation about how this London wide programme of change was developing in the Brent Area (see agenda papers above). It talked about how the possible plans to change services at Central Middlesex Hospital and Willesden Centre for Health and Care were progressing. I pointed out the quantity of meetings that HealthwatchBrent was expected to attend on SHAF meant that it was difficult to get a wider group of patients' views on the changes.

4c Brent CCG

Brent CCG Quality, Safety, Clinical Risk and Research Committee

19 February 2014

Ann O'Neill, Healthwatch Brent Director, writes:
This meeting is the way that the CCG tries to ensure that it is reviewing risks and checking the quality of the services it is purchasing for Brent Patients. The minutes are distributed with the following CCG Governing Body agenda and papers. See right at the bottom of this page for past minutes. http://www.brentccg.nhs.uk/en/governing-body/governing-body-meeting-papers/cat_view/1-publications/3-governing-body-meeting-papers/91-29-january-2014
This meeting looked at reports including

- Pathology service (there have been problems in the past with transporting blood/urine samples to the lab)
- 18 weeks action plan at Northwest London Hospitals Trust (NWLHT)
- Maternity Services
- Safeguarding Training
- Serious incidents
- Performance and Quality Reports on Central and Northwest London Mental Health Trust, NWLHT, Royal Brompton Hospital, Imperial Hospital Trust (Which covers St Mary's which many Brent people use)

- An overall report about how the CCG and its contractors are doing
- Current research

The performance and quality reports are quite long-(even when summarized) and we have asked if a brief summary could be produced of the main concerns that could be included here or circulated to patients, They are produced by the Northwest London Commissioning Unit (CSU) Brent CCG pays them to provide them with information such as this.
The main new concerns currently seem to be around the Royal Brompton Hospital having a backlog of cases which is slowly going down and the Ambulance service not meeting targets. There are action plans in place and they are having to report back usually weekly to the CSU.
They also reported that Maternity services at Northwick Park Hospital now have recruited more midwives and consultants to improve the midwife to baby ratio so this action plan appears to be working.

There is a dispute resolution Policy for Continuing Care which was agreed by the CCG executive in November 2013. This will be circulated to the Committee. The next meeting is in April. [2014]

Brent Clinical Commissioning Group's Quality, Safety and Clinical Risk and Research Committee

Ann O'Neill, a Healthwatch Brent Director, writes:

This committee meets every 2 months for 2-3 hours. Basically it looks at any risks that have been identified by Brent Clinical Commissioning Group [CCG] and the action plans that have been developed to reduce those risks. The agenda is quite long. There are usually lots of reports and charts to look at. For each item someone from the CCG or the Commissioning Support Unit usually does a summary of progress made and answers questions.

The committee asks questions and discusses the issues. Then they decide if they feel what is being done to reduce the risk is enough. If not they ask for more information or action. They look at reports on how local providers such as the hospitals are doing against their targets: or investigations and action plans where a problem has been identified. They are looking to get "assurance" or a guarantee that everything possible is being done to minimise risks to the health of local patients.

Many of these items are then discussed at the CCG Governing Body which is open to the public. Not all the papers we see at this Committee can be seen by the public at the CCG but the approved minutes of the Quality, Safety and Clinical Risk and Research Committee are attached to the CCG's Governing Body papers, so they can be seen by members of the public.
The Agenda has 4 sections:
New Items This section looks at annual reports, for example in August 2013 we looked at the Looked after Children Annual Report, Safeguarding Children Annual report, and details of new proposals about the Integrated Care Programme.

Serious Incidents This month they looked at a report on Serious incidents from local hospitals from 1 August- 30th September and there was an update on Pathology – review of progress against the Action Plan.
Standing Items Here they get updates on plans and issues they have already discussed before. In August we discussed the Safeguarding Self Assessment plan and the Interim Complaints Policy. In October we discussed the Winter Plan, "18 week referral to treatment" action plan for Northwick Park and Central Middlesex Hospitals (There are also many other more technical items).
For information These items are generally minutes from other related meetings so that members can see exactly what else is being discussed in other meetings and agreed to take forward in action plans.
I have been to 4 meetings as a Healthwatch Brent Director. It's hard to read all the paperwork beforehand and they use lots of abbreviations. My impression so far is that they use the information and statistics they get to check Brent Services (both hospitals and community services) are meeting the national targets. Where they aren't they are not afraid to ask probing questions and ask for more action. I generally ask questions about how they have consulted and informed patients and the public about changes or issues, how they are dealing with complaints etc. The other members of the committee have welcomed my questions and comments. At the moment there is a lot of concern about how local hospitals and other services are going to deal with winter pressures and waiting lists.

4d Heath and Wellbeing Board

Health and Wellbeing Board, 26th Feb 2014

Ann O'Neill, Healthwatch Brent Director, writes:
All the papers are here: http://democracy.brent.gov.uk/ieListDocuments.aspx?MId=2194
This is supposed to be in an important meeting but several people were missing. There were only 2 councillors present and no Chief Executive of Brent Council. Brent CCG had 3 senior officers present.
Items discussed:
A report from the Child Death Overview panel.
It talked about road traffic accidents and teenage suicide and asked how they could be prevented. Brent has a low level of child deaths from RTAs but the group agreed to ask officers to check all children get road safety training. The group also agreed to check that teenage mental health advice, information and advice are available in Brent High schools and elsewhere.

Brent Better Care Fund Plan
Phil Porter, the Director of Adult services went through this plan. It aims to keep the most vulnerable people well in the community, avoid unnecessary deaths and ensure that there is effective multi-agency planning when vulnerable people are discharged from hospital. Health, social care and community/voluntary sector services will have to work closer together. Staff roles will have to change and training will be needed to do this. The patient/person will be at the centre.
Brent is involved in the bigger Pioneer project across Northwest London, but this is Brent's plan. There is an Integration Board in Brent which involves patients helping to develop the plan with senior managers

The paperwork explaining all of this is still very complicated and they will need to make it easier to understand so Brent people can understand what they are planning. It needs to start in 2015-6 but the plan needs to be sent to NHS England by April 4th this year so they can check it.

Brent Joint Strategic Needs Assessment (JSNA) "Refresh"

The JSNA is a collection of plans, statistics and information which describes the health and wellbeing needs of Brent. It is used to help develop plans and the statistics in it can be used to develop bids. It was compiled in 2012 and needs to be updated (refreshed). There will be new sections on welfare reform, air pollution, transport and housing. A group of senior mangers are going to work on it and produce a summary in April. You can look at the JSNA here:http://www.brent.gov.uk/your-council/partnerships/health-and-wellbeing-board/jsna/. If you think information in it needs updating please contact Melanie.smith@brent.gov.uk

The Brent Health and Wellbeing Strategy Action Plan

The Board discussed the action plan. Many of the proposals are things the Council or the CCG have to do anyway. They are going to look at which areas the Board could champion in the next year and report back to the next meeting.

"Better Care Fund Plan"- Health and Wellbeing Board Informal Meeting, 12 March

Ann O'Neill, Healthwatch Brent Director, writes:

Councillor Ruth Mower called an extra informal meeting of the Board to discuss the Better Care Fund Plan (see the previous bulletin for details)

I was surprised that yet again only one Councillor was present at the beginning of the meeting. I asked why. There were 2 apologies and 2 had just not turned up. I asked if the Councillors don't think the Health and Wellbeing Board is important. (HWB has 2 named substitutes who can attend the Board, so I would assume Councillors also have named substitutes who could come to the meeting). 3 members of Brent CCG were there again. One councillor (who had sent apologies) turned up halfway through.

The aim of the meeting was to get the Board's feedback on the plan. I was surprised to hear that this "Better Care Fund" actually has no extra money for this plan. They hope that by working closer together they will save 10% that can then be used on more or new services.

NHS England has looked at the draft plan and said very little other than they need to do more work on "Risk outcomes and how they will mitigate any risks"

We looked at the 5 different schemes within the plan. They are:

- Keeping the most vulnerable well in the Community
- Avoiding Unnecessary Hospital admissions
- Effective multi-agency discharge
- Mental Health Improvement
- Key enablers ie things that are needed to enable these changes to happen including support for carers, developing community capital, a range of commissioned services, good IT links, and cultural changes in organizations

They think there are about 5000 people in the 5 GP localities that could benefit from closer working. There is an issue that Adult Social Care currently work with about 2500 people. They won't work with people who don't meet their criteria; people asked how would those patients be supported in the localities? They think there could be an NHS

team based in each locality to work with vulnerable patients. The main difference is that this will be GP led.
There was a discussion about what targets they should set for each scheme. Brent is doing well compared to its "comparators" eg it already has a lower number of people in residential care than other areas, and also does well on people staying at home for 91 days after a hospital stay. It is not doing so well on delayed discharges and is not so good at avoiding emergency admissions. Officers were going to look at more recent data and suggest targets. They will bring the plan to the next Health and Wellbeing Board.

END

April 2014

Brent Better Care Fund Plan:
The plan has been updated since the last meeting. There is more information about possible risks and what they will do to lessen the risks. HWB asked how this plan fitted in with the increase in GP appointments now available at the locality hubs. Patients are reporting that receptionists are not telling them about these available appointments when they ring up and there are no appointments available at their GPs. If surgeries cannot deal with this sort of change how will they deal with bigger changes? Brent NHS said they were looking into why patients were not being told about the hub appointments. It might be that people do not want to travel to other places to see a GP. They have now told 111 about these appointments.

All the documents for this Board are very complex and full of jargon. I have a better understanding of the plans. That is because I have heard the plans explained and discussed at several meetings now and feel confident to ask questions, but other members of the public might still find it all confusing and worrying.

Central Middlesex Hospital Accident and Emergency Closure Project Board meeting, 18 March [2014]

HWB is pleased to report that the patient representatives were made to feel welcome at the Northwest London Hospital Trust meeting about plans to manage the closure of A&E and Central Middlesex Hospital. We will give updates as information emerges.

Health and Overview Scrutiny Committee (HOSC) of Brent Council, 18 March

Gaynor Lloyd, Healthwatch Brent Community Director, writes:
Various topics of substantial importance to Brent residents were discussed, and there are detailed papers available against each agenda item at the following link http://democracy.brent.gov.uk/ieListDocuments.aspx?CId=320&MId=2188&Ver=4)
If anyone is interested to go to future meetings, it is possible to register for email alerts on the Brent Council website. You will then be informed when the agenda and papers are available on the website. The next meeting is on 4 June.
The topics covered were
1 Mental Health Services in Brent – an overview of the mental health services provided in Brent for people with severe mental health issues.
2 Task Group Report on Tackling Violence against Women and Girls in Brent.
3 Future of Central Middlesex Hospital [CMH] and Willesden Centre for Health
4 Redesign and Investment in Diabetes Service in Brent.
5 18 week referral to treatment and Urology Serious Incident.

Many members of the public attended the committee, with an interest on some or all of the items.

• **Bureaucracy first, patient last.** The service appears to be managed to enable point scoring against checklists. If you cannot have your box ticked, you do not receive the service. Her psychiatrist was forced to discharge her because she did not have the right score, even though in the psychiatrist's clinical judgement, she still needed her help.
□ **Withdrawal of community services.** There used to be a day hospital in Wembley Hospital where the following is available – group therapy; cultural activity – painting, writing, discussion groups; physical activity – keep fit, Pilates; meals for people unable to manage self catering; classes on lifestyle management. It was staffed by a multidisciplinary team of occupational therapists, psychologists, nurses, social workers and people from adult education, with access to psychiatrists when necessary.
□ **All gone** – domiciliary visits from social workers and psychiatric nurses only for crisis intervention with onus on the patient to be responsible for contact, usually only an answerphone available and, in her experience, no one rings back.
□ **Cost reduction** – All the above, led by cutting budgets. Commissioners regard mental health services as an owner's necessity and see them as a good source of savings. Talking therapies limited. Overreliance on management through medication (because this does not involve staff time). The government now proposes to cut a further 20% off the mental health budget.
Some services – such as occupational guidance – can be obtained for people on income support but, for those with any financial means, they – or their families – have to cope.

There may have been some result from the presentation. Officers from CNWL followed her out of the meeting, and have asked her to assist them. The same officer also made contact with the HWB representative afterwards. Some reflections on the service user's experiences were incorporated in the presentation by CNWL which followed.

The HOSC committee were also very fierce on the proposals for the new premises for CNWL's inpatients on the CMH site. At previous HOSC's, members have put forward concerns about the loss of open space, and those concerns were added to on the subject of buildings around the new proposed open space. Councillors have visited the site, have criticised the initial plans and asked for them to be brought back to the committee answering their concerns. The committee were also more impressed by the space available for mental health service users at Northwick Park Hospital.
The papers on the subject of "Tackling Violence against Women and Girls in Brent" are detailed and shocking but it was good to see the proactive and firm stance being taken by Brent Council. Gynaecology is one of the outpatient services currently being re-tendered by Brent CCG, and HWB representatives have consistently requested that FGM matters are strongly taken into account, when considering the services.
The diabetes paper was presented by a local GP, and all the facts are in the paper. I particularly noted that there has been a nationally dictated change in screening for diabetics. I noted this particularly, as HWB is involved in a Vision Strategy exercise
As to the Urology Serious Incident, this is clearly of concern and appears to relate to faults in diagnosis. If of particular interest, we suggest you look at the paper,
For anyone who is interested, the minutes of HOSC meetings are always very full and it will be worth visiting the website to check on these in a few weeks.
For those particularly interested in the diabetes service, there was a detailed discussion at the previous HOSC, all of which is covered in the minutes.

Health and Wellbeing Board, 9 April

Ann O'Neill writes: There were 3 councillors present for this meeting from the start. I have yet to see 2 councillors at any of the meetings I have been to since June last year. This is a key meeting where Brent Council and Brent NHS meet to discuss important health and social care plans and issues, but it seems as if some councillors don't take it seriously. I found out that they do not have a substitute system, i.e. if they can't attend they don't have a replacement who could attend in their place. HWB will suggest that a substitute system is introduced for the Board.

Click on this link for the agenda and papers:
http://democracy.brent.gov.uk/ieListDocuments.aspx?CId=365&MId=2195

4e Other documents

New 5 Year Cancer Commissioning Strategy for London

NHS England published its final 5 year cancer commissioning strategy. The new measures include lowering the age of referrals, speedier access to tests, and more community programmes to help people spot the early signs of cancer. Plans for the first year focus mainly on early detection of cancer. There are also plans for the improvement in the care and support for the increasing numbers of people living with and beyond cancer. To find out more about the strategy click here.

NHS
Brent
Clinical Commissioning Group

Chair: Dr Etheldreda Kong
Chief Officer: Rob Larkman
Chief Operating Officer: Jo Ohlson
31st March 2014
Dear Colleague
I am writing to let you know some important decisions Brent CCG Governing Body made on 26 March 2014 and the eight CCGs on 27 March 2014. Three important decisions were made.
Taken together, these decisions will hugely improve our ability to deliver better services for all our patients across a vast area of London. This is a key moment for the development of the NHS in the hands of its leaders, the GP community.
The three decisions are: 1. A new joint financial strategy to deliver the Shaping a healthier future reconfiguration programme All eight of the North West London CCGs have agreed to put funding into a central budget to help deliver our reconfiguration programme. If approved by NHS England, the fund will be worth £139m for 2014/15, with a commitment to continue the strategy for the next five years. It will mean that CCGs that have a surplus

budget will support those CCGs with a deficit, so resources will be shared across CCG boundaries to ensure more equity of funding. Specifically, this will enable CCGs to make the following investments: £57m to deliver Shaping a healthier future, the large scale reconfiguration plan which will create five major acute hospitals in NW London; £35m to ensure there is more level 'financial playing field' between CCGs; £47m to improve out of hospital services such as seven day opening and community services. 2. Exploring with NHS England a different way of financing and commissioning primary care services The eight CCGs have agreed to work with NHS England to bring the commissioning of primary care together across organisational boundaries. This will enable us to make the further

Executive Office
Wembley Centre for Health & Care
116 Chaplin Road
Wembley
Middlesex HA0 4UZ
Tel: 020 8795 6485
Fax: 020 8795 6483
Email: etheldreda.kong2@brent-harrowpcts.nhs.uk
www.brentccg.nhs.uk

investments in primary care needed over the next few years, to support the shift in services from hospital to community settings and transform care for patients. This new arrangement will be a significant development for GPs and for the NHS, and will enable us to buy and plan health services more strategically, effectively and sustainably. 3. Review of commissioning support services We have almost completed a review of the services we currently purchase from the NW London Commissioning Support Unit and will be publishing this at the end of April. This will set out ideas for how we can have greater control over commissioning support services so they can better meet our requirements. Our decisions now have to be approved by NHS England, and we will keep you informed of progress of this important work. The eight CCGs issued a press release on 27 March, and this was published on each CCGs' website.

I would also like to take this opportunity to explain the reasoning behind Brent's decision to agree to the NWL financial strategy to which we are a net contributor.

As you know Brent CCG has been working in close collaboration with the other seven CCGs in North West London to implement:

Shaping a healthier future. Out of hospital care. Whole system integration of primary, community and hospital services with social care.

Brent CCG agreed on 26 March to support a financial strategy across the 8 NWL CCGs that will provide:

1. Pooling of CCG and NHSE non-recurrent uncommitted allocation so called headroom. All CCGs are required to make a provision for 2.5% headroom. A similar pool was created in 2013/14. This pool will be used to support non recurrent costs arising from the Shaping a healthier future programme that will secure safe sustainable acute services in North West London. Brent will contribute £9.4m to this pool in 2014/15.

2. An out of hospital non-recurrent implementation fund so that all CCGs are placed on a common footing. Those CCGs who are currently receiving funding below their target allocation will be able to implement their out of hospital strategies. This pool is being

created by those CCGs with large surpluses including Brent contributing to the pool. Brent CCG is contributing £11.7m to this fund.
3. An out of hospital recurrent investment fund. Brent is contributing £12.1m to this fund but will receive £5.9m back to invest recurrently in out of hospital services.
Brent Governing Body members have supported this financial strategy because:
Shaping a healthier future is a NWL-wide programme that we all depend on for safe and sustainable acute services. Successful implementation will be significantly enhanced by a NWL-wide financial strategy.
3
Individual CCGs are in radically different financial positions with surpluses/deficits which are predominantly the result of inherited PCT positions, and surpluses/deficits correlate with under/over funding positions.
If the wide disparity in CCG financial positions is not addressed through a NWL-wide financial strategy, Shaping a healthier future implementation as a whole could be compromised.
A NWL-wide financial strategy provides resilience to all CCGs including Brent CCG in the light of potential future funding changes and also in facing provider issues together.
Brent CCG is currently in a strong financial position. Under the NHSE funding allocations for CCGs approved in December 2013, Brent CCG is deemed to receive too much funding for its patients based on a needs based national formula. In 2014/15 it will be 7.7% from target. Over the coming years, Brent will receive less growth than CCGs who are below their target allocation eg. Harrow and Hillingdon who are 9.9% and 8.8% away from target respectively. Nonetheless Brent will remain in a strong financial position but with a smaller surplus. In 2014/15 we have a planned surplus of £18m. NHSE expect/require CCGs to operate within a 1% surplus. Nationally those CCGs who have a surplus in excess of 1% tend to be those CCGs who are over target in respect of the funding they should receive based on their population. We will continue to have both a recurrent and non-recurrent investment programme in 2014/15. £7.1m recurrently and £18.7m non-recurrently investing in local services. Working together in this way will give Brent greater resilience in the longer term as Brent CCG receives minimum growth.
If you have any questions, please do get in touch with my office.
Yours sincerely
Dr Etheldreda Kong
Chair

4f Integrated services

Oct 2013

Integrated Care

There is a lot of talk about 'integrated care. Many organisations such as local authorities, the

NHS, care and support providers, education, housing services, public health and others will have to work together to make it work.

Click on this link to find out more:

http://learni.st/users/140647/boards/39490-making-integrated-care-happen

nov 2013

HWB does not know the outcome of submissions to this questionnaire -

NHS England – A Call to Action

The NHS England London Region has published 'London – A Call to Action' This document highlights some of the trends and challenges for the NHS in London.

The document builds on NHS England's national 'Call to Action' document that was published in July. It said that the NHS must transform in order to continue to deliver the best care to those who need it.

There is also an online questionnaire for you to comment. You can find the reports and the questionnaire by clicking on this link:

http://www.england.nhs.uk/london/london-2/ldn-call-to-action/ respond by 31 Dec 2013

Integrated Care
HWB is aware that one of the SaHF CCG workstreams focussed on WSIC, but is not aware of progress, or how this fits with other guidance such as -
There is a lot of talk about 'integrated care. Many organisations such as local authorities, the NHS, care and support providers, education, housing services, public health and others will have to work together to make it work.
Click on this link to find out more:
http://learni.st/users/140647/boards/39490-making-integrated-care-happen

Dec 2013

Better Integration Transformation Board

Healthwatch Brent is taking part in the Better Integration Transformation Board. Members of this Board discuss plans how health and social care can work together better for the benefit of service users. They report to the Health and Wellbeing Board. This is all part of the changes to the way health and social care will be provided from April 2014. These plans tie in with Brent CCG's Out of Hospital Delivery Strategy, which aims to ensure accessible, pro-active and co-ordinated care, and the North West London pioneer programme of Whole Systems Integrated Care (WSIC).

The first Integration Board meeting also had an initial discussion about priorities for integration and the two year plan. Click on this link to find out more:

http://democracy.brent.gov.uk/documents/s20810/health-and-social-care-integration.pdf

Healthwatch Brent is working through Brent CVS (Council for Voluntary Services) to assist with consultation. Find out about events in the new year on Healthwatch Brent or Brent CVS websites (http://www.cvsbrent.org.uk/).

Brent CCG is holding an event on 12th February which will include some of the thinking behind the integration project.

4g Closure of CMH A&E project board

Brent CCG staff changes

NHS Commissioner James Lorigan has left his post at Brent NHS. A member has reported that 80% of the Commissioners have been "laid off".
Healthwatch Brent is trying to find out who the new or remaining Commissioners in Brent Clinical Commissioning Group (CCG) are and what their area of responsibility is. So far we have not had a response from the CCG to our enquiry.

April 2014
Brent CCG staff changes: HWB is still trying to find out who the new or remaining Commissioners in Brent Clinical Commissioning Group (CCG) are and what their area of responsibility is. It seems that this has now been turned into a Freedom of Information Request and we are awaiting the reply eagerly.

4h Merger programme

4i Confusion

"The more I find out the more I get confused. I wonder if they are doing this on purpose to fudge issues and prevent us knowing what's going on" HWB member.

"I have been to patient participation groups but it is confusing to know what is going on. The system seems very complicated." HWB public meeting

HWB received updates about closures and likely changes to hospital changes at CMH and Northwick Park Hospital (NPH) from the CCG and Merger Programme, but not about new community services that SaHF promised – some relevant info below.

Update on CCG staff changes:
Healthwatch Brent had asked the following questions about the new or remaining Commissioners in Brent Clinical Commissioning Group (CCG).

- How many commissioners are there within Brent CCG?
- What is their role/area of responsibility?
- Are their posts permanent or interim (if the latter how long for?)

The CCG turned this into a Freedom of Information request. The answer was a chart with lots of acronyms (abbreviations) as a reply. Unfortunately, we have not had an answer yet to how long the interim posts are for:

Some of the acronyms explained (in order of appearance):

SRO	-	Senior Responsible Officer
OD	-	OrganisationalDevelopment
NWLH	-	North West London Hospitals
SaHF	-	Shaping a Healthier Future
CCG	-	Clinical Commissioning Group
OSC	-	Overview and Scrutiny Committee
QIPP	-	Quality, Innovation, Productivity and Prevention
PbR	-	Payment by Results
GP IT	-	General Practitioner Information Technology
MSK	-	Muskuloskeletal
WSI	-	Whole Systems Integration
STARRS	-	Short Term Assessment, Reablement and Rehabilitation Service
ICP	-	Integrated Care Pathway
CSU	-	Commissioning Support Unit
LTC	-	Long-term condition
ICO	-	Integrated Care Organisation
LAC	-	Looked After Children
CNWL	-	Central Northwest London Hospital Trust
IAPT	-	Improving Access to Psychological Therapies
CAMHS	-	Child and Adolescent Mental Health Services
PPE	-	Patient and Public Engagement
EDEN	-	Equality, Diversity and Engagement Network
LES	-	Local Enhanced Service

We are still waiting to hear from the CCG what the following acronyms mean:

TB - ChC - ITF - DN - DMARD - RFS

We welcome any clarification on these.

5 Other

5a NWLHT financial trouble

Feb 2014

North West London Hospitals NHS Trust

A study of NHS foundation trusts in England has found the number of those in financial trouble has nearly doubled in a year from 21 to 39.
The North West London Hospitals NHS Trust, which runs Northwick Park Hospital, St Marks Hospital and the Central Middlesex Hospital, is anticipating that by March it will have a debt of about £20million. This will be the third successive year that the Trust has operated at a loss and there is concern that there will be cuts to the services. It is planned that the North West London Hospitals NHS Trust will merge with the Ealing Hospital NHS Trust in July.

5b CQC reports on NPH and CMH

Care Quality Commission [CQC]

The Chief Inspector of Hospitals is asking people to tell him about the care provided by two local hospital trusts: the Royal National Orthopaedic Hospital NHS Trust and the North West London Hospitals NHS Trust.
These Trusts are among the first to be inspected and given an overall rating under radical changes which have been introduced by CQC. Your views and experiences will help inspectors decide what to look at when they inspect the trusts in May. People are being encouraged to attend the listening events to find out more about the inspection process, to tell the team about their experiences of care and to say where they would like to see improvements made in the future. The inspection team is expected to look in detail at eight key service areas: A&E; medical care (including frail elderly); surgery; intensive/critical care; maternity; paediatrics/children's care; end of life care; and outpatients.

Royal National Orthopaedic Hospital NHS Trust

The formal inspection of the trust will start on Tuesday 6 May when the inspectors will be holding a listening event:
When: Tuesday 6th May, 6:30pm
Where: Stanmore College, Elm Park, Stanmore, Middlesex, HA7 4BQ

North West London Hospitals NHS Trust (Central Middlesex Hospital, St Mark's Hospital and Northwick Park Hospital)

The formal inspection will start on Tuesday 20 May when the inspectors will be holding a listening event:
When: Tuesday 20th May, 6:30pm
Where: Quality Hotel Wembley, Conference Centre, Empire Way, Wembley, HA9 0NH
CQC is asking people who would like to attend the listening events to fill in an online form at www.cqc.org.uk or call 03000 61 61 61. This will help with planning for the event, but people are free to turn up on evening even if they haven't registered.

CQC is asking people who would like to attend the listening events to fill in an online form at www.cqc.org.uk or call 03000 61 61 61. This will help with planning for the event, but people are free to turn up on e evenin even if ey aven' e is e ed.

If you are unable to attend the events but wish to give your views you can do this: • Online http://www.cqc.org.uk/contact-us • By email enquiries@cqc.org.uk • By le e CQC, Ci y a e, Gall a e, Ne as le n Tyne, NE1 4PA • By ne 03000 61 61 61
The CQC will publish a full report of the inspector's findings later in the year. The Trust will be one of the first receiving one of the following ratings: Outstanding, Good, Requiring improvement, or Inadequate.

NHS
Brent
Clinical Commissioning Group

NWLH Merger Update

The date for the merger of the hospitals for patients in Brent, Ealing and Harrow has changed from July 2014 to October 2014. This is to allow the NHS Trust Development Authority, NHS England and the local Clinical Commissioning Groups more time to complete everything that is necessary before the merger can be approved.

You can contact the merger programme team on 020 8869 3298 or email merger@nhs.net if you have any queries.

Survey of patients using A&E / UCC
At Northwick Park Hospital
February 2015
www.healthwatchbrent.co.uk Tel 0800 996 1839

Healthwatch Brent

Healthwatch Brent gathered the views of 35 patients using A&E / Urgent Care Centre at Northwick Park Hospital in December 2014, and a further survey of 62 patients was carried out in February 2015.
This was in response to this A&E having one of the worst waiting times in England, and to the following description of a visit, sent to Healthwatch Brent.

My father had been in bed for approx. 2 weeks- due to a cut on his leg getting infected. Starrs came out and took bloods- same day GP phoned and said need to go to A&E and will stay in- due to blood sugar levels and potassium levels, couldn't walk so sent ambulance.
Got to A&E just after 9pm, had to queue with all others who had come in via ambulance- queue was literally out the door. People were having bloods taken while waiting in the queue. Ambulance staff had to wait to book in their patient and then wait for them to get a bed before being able to leave to help others. Say roughly an hour and a half or 2 hours later- finally got a bed- was told not to eat or drink anything (even though he is diabetic and was told he was dehydrated) - lovely nurse went and checked and allowed him to eat something.
Blood sugar levels were taken and ECG (bloods were over 20)- wasn't given any medication- or anything to bring down his blood sugar levels for the whole night, had to ask twice for pain relief.
One doctor came- he explained the whole story to him- assessed him- sent him for an x ray. Came back said medics were expecting him so someone would see him.
Nurses or health practitioners (Sree and Joseph) very nice and friendly- took time to assist. Also the guy taking coffees around was very friendly and helpful. All doctors didn't want to make eye contact, seemed like they couldn't be bothered. Finally saw a woman doctor who made him explain whole story again- didn't seem to care, showed no customer care and clearly hadn't even read his notes. Said it's a stiff knee so he can go home- was told to check his x ray (as she wasn't aware)- had to find her to see if she had checked it. She said its fine he can go home- asked how he could get home- said to catch a cab rudely (knowing he wasn't able to walk)!! When we said he cant walk she said to speak to a nurse as she didn't know how it works.
Whole experience was a joke!! Got home after 4.30am and they done absolutely nothing. Apparently now he has tendinitis and is still in bed!!!!!!!!!!
Concerns for other patients especially elderly and disabled as they did not seem to care at all, frail elderly woman who had previously been discharged from the hospital as she was able to take 2 steps had to wait over 1hour 40 mins to get a bed and then be seen.
Lady with mental health problems was wondering- staff who dealt with her didn't seem to care.

Family member of patient, November 2014

The surveys

Healthwatch Brent volunteers and staff interviewed 35 patients during three 2 hours visits -one on a mid-week daytime, one midweek evening, and one Sunday.

The visit was limited to the newly opened joint reception and waiting area for A&E and the Urgent Care Centre (UCC). Most of the patients did not know if their service would be provided by A&E or the UCC, although most seemed to be for the UCC.

We did not know how long these visits took to complete after the interview. 2 of the 3 visits seemed to be at quiet times. We interviewed only 1 person who had waited over 4 hours. Healthwatch Brent does not know how representative these were of average weekly visit volumes around that time.

Healthwatch Brent also conducted a survey of 62 patients via a survey conducted by small groups and organisations in Brent. See 'Survey of Brent A&E Patients Feb 2015', supplied separately.

In contrast to the experiences reported on-site and reported below –

- Only 5% of patients reported being seen in less than 15 minutes of arrival versus 50% waiting over an hour.
- 76% waited over an hour to be examined, 21% over 3 hours, and 8% over 4 hours.
- 16% of people were told how long they would have to wait, 66% were not told.
- 25% of visits took between 4 and 8 hours to complete.

Healthwatch Brent reflections on on-site patients' views

The proportion of people coming from Harrow was surprisingly high.

The number of people using A&E on repeat occasions was surprisingly high.

There was a lack of awareness of GP Hubs as a route to quicker GP appointments.

There was a lack of awareness of the Urgent Care Centre at Central Middx. Hospital as an option.

Access –

People were concerned about parking charges for long and uncertain waiting times.

Some people found signage to the new A&E/UCC was poor.

Some people found the walk to the new unit was unsafe and long.

The process –

People were pleased to have been seen by a nurse within 10 minutes of arrival.

What happens next and waiting times were not made clear to most people.

Dignity, kindness, and respect –

Between 77% and 91% of people gave positive feedback. No one gave negative feedback.

The environment –

Most people were pleased with the new reception / waiting area.

Some suggestions were made for improvement.

Waiting times –

A number of people said the waiting time was better than previous visits.

A number accepted that waiting was what they expected.

A significant number of people said that the waiting time was something that would improve the service.

The following **questions** were sent **to Tina Benson, Operational Director, Northwick Park Hospital -**

1. How did patient numbers this week compare to previous December weeks?
2. How did patient numbers during these timed visits compare to other times that week?
3. What percentages of patients were seen within 4 hours during this week?
4. Can you give us a projection of how you expect visiting times to compare to this week, and the November 2014 low of 65% patients seen within 4 hours.
5. How do you measure waiting times?
6. We only took a snapshot off patients in reception - how much of people's waiting time is spent in reception?
7. Please give us an update on your plans to reduce waiting times, and any progress you have made so far.
8. Do you have any comments to make on this summary of patients' views?

Healthwatch Brent request a response to these questions from Tin Benson

Patient suggested improvements –

Reduce waiting times
Give patients a clear estimate of likely waiting time
Improve the patient calling service, using a message board
Install a clock
Make healthy drinks and snacks available to purchase
Change machine – to convert notes into coins for vending and parking machines
Improved distractions for those waiting – TV with subtitles, magazines, Wi-FI
Ensure cleaning is done on a regular basis, or spillages responded to quickly
More bins
Sanitiser dispensers
Review / improve signage to the unit, from car parks and main entrance
Review / improve safe pedestrian access to the unit

Healthwatch Brent asks Tina Benson to respond to these suggestions.

Survey of Brent A&E Patients Feb 2015 are included as a separate report.

Healthwatch Brent asks Tina Benson to reflect on this report, and to give her responses.

The questions we asked	The responses patients gave us
Which borough do you live in?	Harrow 21 60% Brent 10 28% Ealing 2 6% Hillingdon 1 3% Lambeth 1 3%
Have you used A&E before?	Yes 28 80% No 7 20%
Which hospital was that?	Northwich Park 23 Ealing 2 Central Middlesex Hospital 1 Barnet 1 Moorfields 1 Royal Free 1 None 7
How often have you used A&E in the last year?	5 times 3 4 times 2 3 times 6 2 times 5 1 time 12 0 times 7
Do you know about GP hubs?	Yes 6 = 3 Brent and 3 Harrow No 29
Do you know about the Urgent Care Centre at Central Middlesex Hospital?	Yes 12 34% No 23 66% 4 Brent 7 Harrow 1 Ealing
How did you get here?	Car 14 Lift in car 5 Public transport 12 Taxi 2 On foot 2 Ambulance 1 The only problem expressed was parking charges
What happened when you first arrived here?	Almost everyone went straight to reception and was registered One person reported no one at reception for 5 minutes on arrival 3 people went to the old department first 1 person arrived with a referral letter form GP 1 came for a follow up following a previous visit 1 person went for an x-ray then to A&E 10 people described the process more fully, most said they were seen by a

	nurse on arrival, in 10 minutes, and one 45 minutes after arrival. For most, this was followed by a wait to be called for treatment. 32 people had given a sample and were waiting for results – these were the longest waits reported. 1 person signed in and was waiting without yet seeing the nurse. Only 3 people said they waited over 2 hours. One person said they waited over 4 hours. All others where waiting, having arrived within a hour of our visit. 2 people were sent to surgery straight after being seen by the nurse. 1 person was referred to a doctor by the nurse and was waiting.

Were the reception staff -	% Yes	% No response	% No
Polite?	91	9	0
Sympathetic?	80	20	0
Understanding?	83	17	0
Did staff treat you with -			
Dignity?	77		0
Kindness?	83	17	0
Compassion?	77	23	0
Courtesy?	77	23	0
Respect?	80	20	0

Have you been told what will happen next?	Yes 7 No 28
Have you been told how long you might have to wait?	Yes 10 No 25 Every time I ask (about 4 times) told 30 minutes – that's ok-busy about 30 mins. 20 mins. 20 mins. About 2 hours but maybe longer-will ask at desk It's better than before - sometimes you waited along time before seeing someone, I have spent 4 to5 hours in the past
Can you tell us about the atmosphere here?	**Everyone made positive comments about the new department.** The key descriptions were –

	Quiet and calm Nice, new, clean, spacious, comfortable, hi tech, good More welcoming 5 people said is was all right or ok I like separation between kids and adults, can see its new didn't think it would be this crowded I brought my son here before the change, before there was no space, too many people, not enough seats its relaxed-better than before the changes-more welcoming does not feel intimidating, more welcoming and modernised feels too relaxed to be A&E **Suggestions for improvements -** drinks expensive and unhealthy, vending machines don't take notes a TV with subtitles or music required
What has been good about this service?	8 people reported a pretty quick / very quick service 6 people said the environment was good 6 people said there was nothing good / nothing particularly good Very busy but thorough Staff listened and understood Nurse talked to me straight away Staff polite, professional Nothing to compare it to Process smoother than before Feel treated well: good at answering questions and made to feel relaxed. Nothing special, standard NHS service Quick and efficient, you know what's going on, that's all you need.
What would make this service better?	**Waiting time** Waiting time too long, have to ask staff about waiting Waiting times- its improving compared to what it was x4 Waiting time quicker- last time I waited 6-7 hours (was 11pm) at night Speed it up, more staff More staff, doctors- waiting times Less waiting times, not sure how realistic that is- it depends on the demand Its good - just the waiting-no one says anything - its quicker at the GP **The environment** Not coming and shouting out your name, can't hear as the unit so big - a screen or speaker with name would be better. X2 Need a clock, free coffee machine for the wait Needs- free Wi-Fi – [during the long wait] Entertainment, books, newspapers TV or light music Spillages on floor, cups, cleaning, needs more bins, more hand sanitisers It's a little dirty Parking not clear A vending machine with healthy options instead junk

	Walking distance is too far for people using buses-it's is very long from and entrance No easy walking route to new building (have to walk on the road) Maps not clear where A&E is , had to ask, the walk to new A&E did not feel safe, had to cross road, security issue location is poor, risks to female walking alone at night outside Signage for A&E parking could be clearer Very busy It's costing money because of the parking- that's stressful. Not enough disabled bays its good they now have more toilets need more comfortable seats, no shop here, more awkward, need free Coffee machine / coffee machine works **The process** Pretty good - noticed and dealt with quickly- informed Being more aware of waiting time that's real not ballpark Name shouting is not clear at all, people with bad hearing cant hear it. Approx. wait time, display off, patient calling system knowing how long wait is Have a doctor at reception would trust him more Be seen instantly Be seen quicker if your in more pain Its ok, just the waiting
How does using this service make you feel?	Hate hospitals- don't like having to be here but have to get health checked Comfortable, environment really nice-better atmosphere than other side Very accessible Hopefully it will put my mind at rest about the pain, then ill go back home Its very good / good / alright / better than most – 7 people Its ok / alright / not too bad - 6 people Should have come here first Good experience Wished had not come but necessary Cared for, accessible Don't like the seating Grateful - they try their best Feel you have somewhere to go when no doctors available Human Previously I was very happy with the service Grateful about resources at least some help Radiologist was good Quiet because of xmas Best experience ever in A&E

Healthwatch Brent

24/02/15

62 responses

View all responses Publish analytics

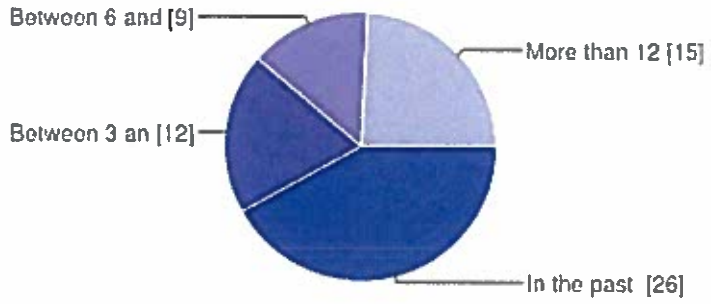
Summary

[Image]

Survey about Changes to Accident & Emergency (A & E)

A & E Changes Survey

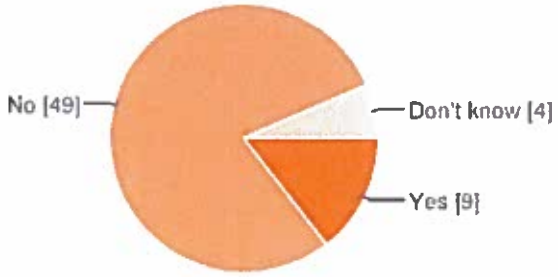
When did you last attend A & E?



In the past 3 months	**26**	42%
Between 3 and 6 months ago	**12**	19%
Between 6 and 12 months ago	**9**	15%
More than 12 months ago	**15**	24%

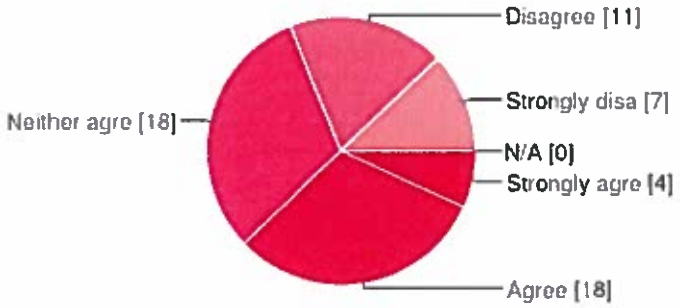
On arrival at the A & E

Were you ever waiting on a trolley?



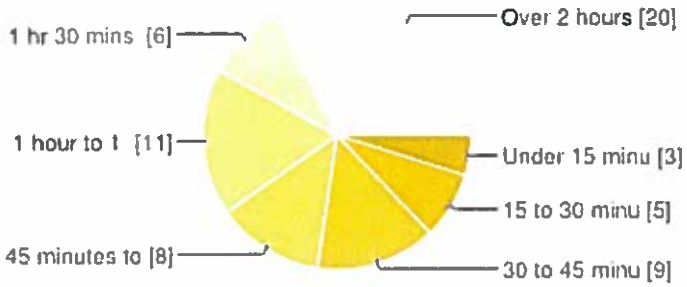
Yes	**9**	15%
No	**49**	79%
Don't know	**4**	6%

I had privacy when discussing my condition with the receptionist



Strongly agree	**4**	6%
Agree	**18**	29%
Neither agree nor disagree	**18**	29%
Disagree	**11**	18%
Strongly disagree	**7**	11%
N/A	**0**	0%

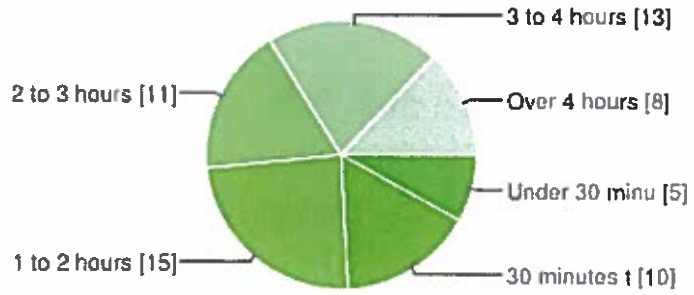
From arrival time, how long did you wait before you first SPOKE to a nurse or doctor?



Under 15 minutes	**3**	5%
15 to 30 minutes	**5**	8%

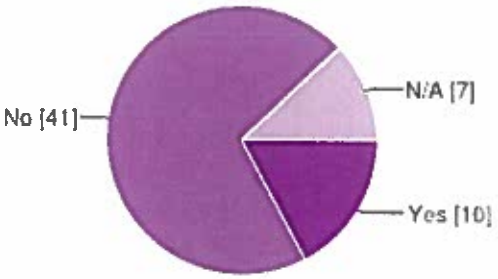
30 to 45 minutes	**9**	15%
45 minutes to 1 hour	**8**	13%
1 hour to 1 hr 30 mins	**11**	18%
1 hr 30 mins to 2 hours	**6**	10%
Over 2 hours	**20**	32%

From arrival time, how long did you wait before being EXAMINED by a doctor or nurse?



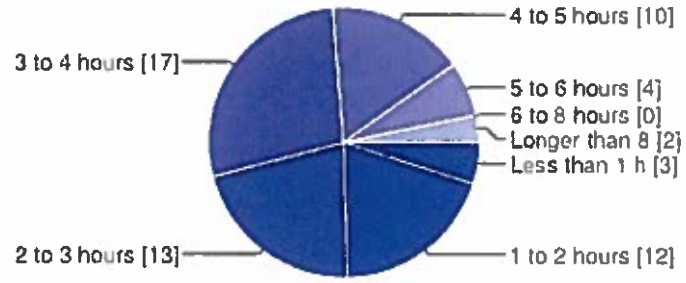
Under 30 minutes	**5**	8%
30 minutes to 1 hour	**10**	16%
1 to 2 hours	**15**	24%
2 to 3 hours	**11**	18%
3 to 4 hours	**13**	21%
Over 4 hours	**8**	13%

Were you told how long you would have to wait to be examined?



Yes	**10**	16%
No	**41**	66%
N/A	**7**	11%

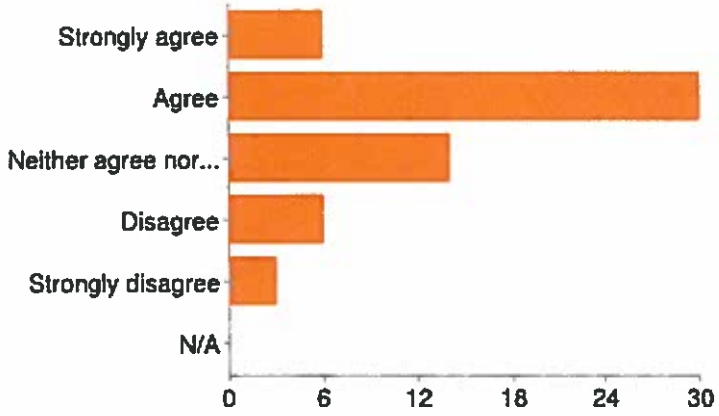
Overall, how long did your visit to A & E last?



Less than 1 hour	**3**	5%
1 to 2 hours	**12**	19%
2 to 3 hours	**13**	21%
3 to 4 hours	**17**	27%
4 to 5 hours	**10**	16%
5 to 6 hours	**4**	6%
6 to 8 hours	**0**	0%
Longer than 8 hours	**2**	3%

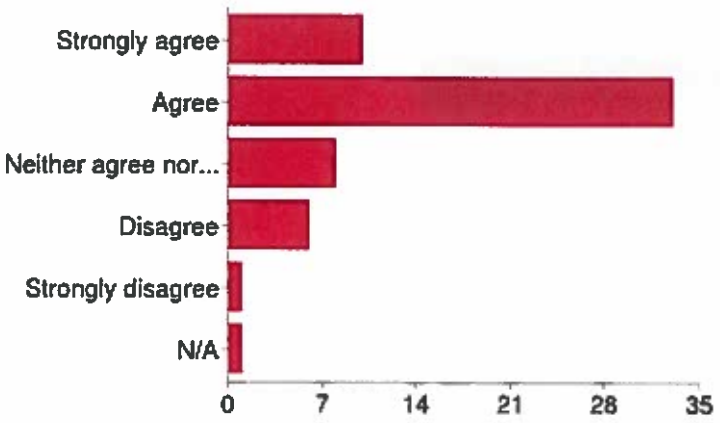
Experience with a doctor or nurse at A & E

I had enough time to discuss my health or medical problem [Experience with a doctor or nurse at A & E]



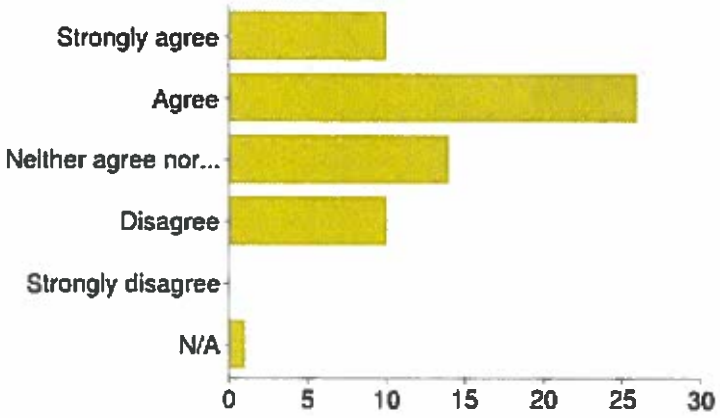
Strongly agree	**6**	10%
Agree	**30**	48%
Neither agree nor disagree	**14**	23%
Disagree	**6**	10%
Strongly disagree	**3**	5%
N/A	**0**	0%

They explained my condition and treatment in a way I could understand [Experience with a doctor or nurse at A & E]



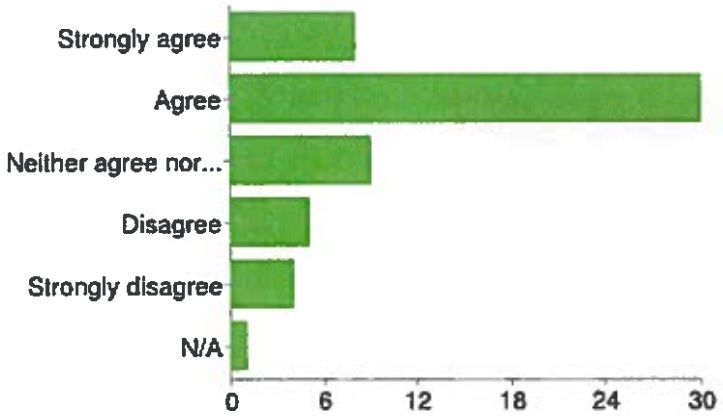
Strongly agree	**10**	16%
Agree	**33**	53%
Neither agree nor disagree	**8**	13%
Disagree	**6**	10%
Strongly disagree	**1**	2%
N/A	**1**	2%

They listened to what I had to say [Experience with a doctor or nurse at A & E]



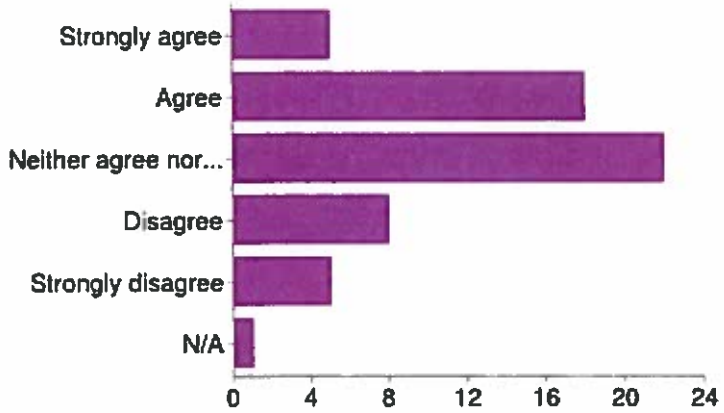
Strongly agree	**10**	16%
Agree	**26**	42%
Neither agree nor disagree	**14**	23%
Disagree	**10**	16%
Strongly disagree	**0**	0%
N/A	**1**	2%

They knew enough about my condition and treatment [Experience with a doctor or nurse at A & E]



Strongly agree	**8**	13%
Agree	**30**	48%
Neither agree nor disagree	**9**	15%
Disagree	**5**	8%
Strongly disagree	**4**	6%
N/A	**1**	2%

I was involved in decisions about my care and treatment [Experience with a doctor or nurse at A & E]

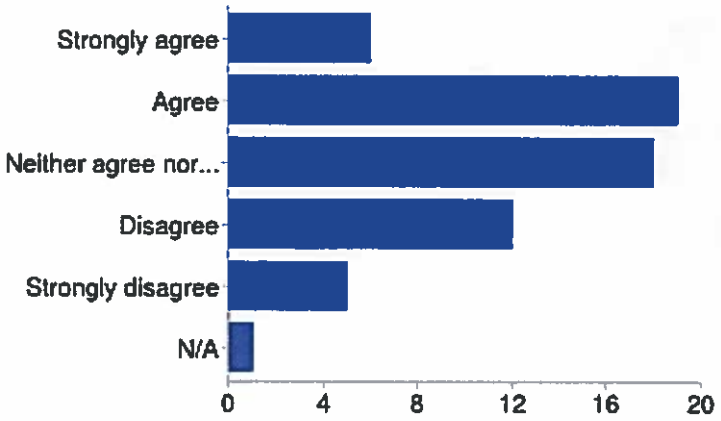


Strongly agree	**5**	8%
Agree	**18**	29%
Neither agree nor disagree	**22**	35%
Disagree	**8**	13%
Strongly disagree	**5**	8%
N/A	**1**	2%

Before leaving the A & E

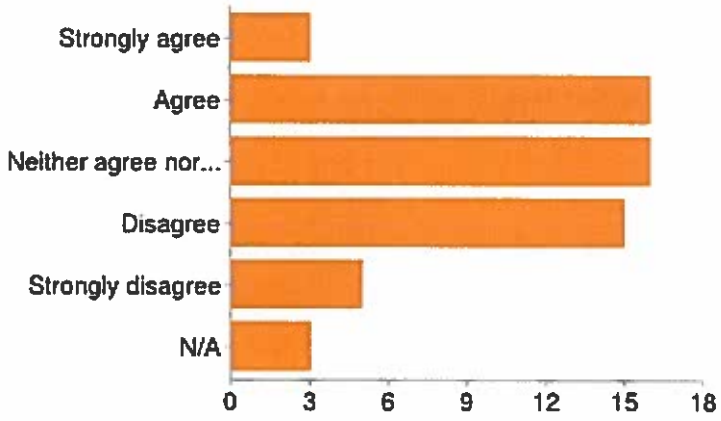
Staff told me who to contact if I was worried about my condition or

treatment after leaving A & E [Before leaving the A & E]



Strongly agree	**6**	10%
Agree	**19**	31%
Neither agree nor disagree	**18**	29%
Disagree	**12**	19%
Strongly disagree	**5**	8%
N/A	**1**	2%

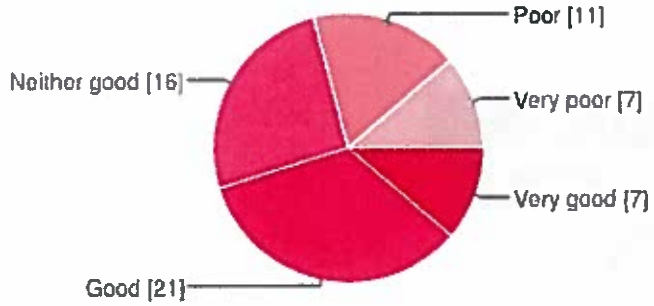
Staff took my family or home situation into account when leaving A & E [Before leaving the A & E]



Strongly agree	**3**	5%
Agree	**16**	26%
Neither agree nor disagree	**16**	26%
Disagree	**15**	24%
Strongly disagree	**5**	8%
N/A	**3**	5%

Overall experience at A & E

Overall, how would you rate your experience at A & E?



Very good	**7**	11%
Good	**21**	34%
Neither good nor poor	**16**	26%
Poor	**11**	18%
Very poor	**7**	11%

Please add any additional comments about your experience at A & E

Nursing staff were friendly. But no one seem to know how long I would be waiting

A & E need to change the overall system

Nurses and doctors were all very good. Thank you

The staff were very friendly at my local AE

The experience I am rating involved a possible cardiac arrest incident. Everything was highly prioritised and very efficent

Doctors and nurses were great waiting times could be better

Quicker waiting times

Boring but relaxing

A & E need to change in terms the overall system and see individuals quicker

I haven't had any privacy at all ,I wasn't involved any decision in my treatment is not even clean environment.

the A&E waiting time is too long

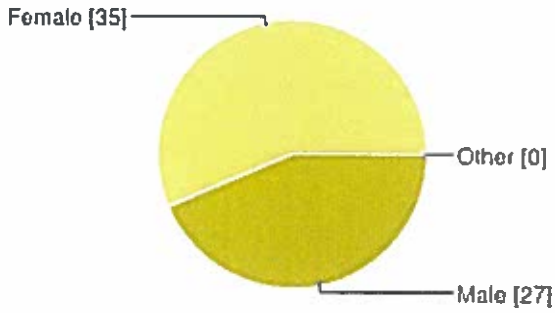
I have been by receptionist first and the same person become nurse afterwords she was the doctor 3 in 1

Nurse really helpful, doctors were good also

Did not give much attention

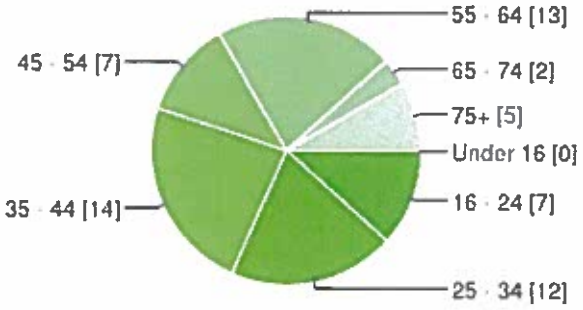
Equal Opportunities Monitoring

Gender



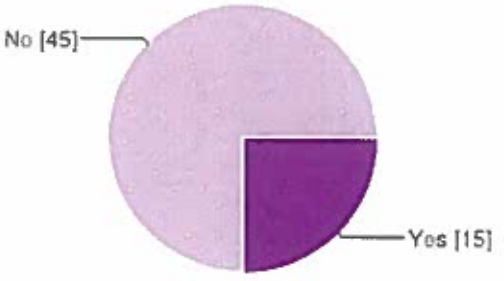
Male	**27**	44%
Female	**35**	56%
Other	**0**	0%

Age



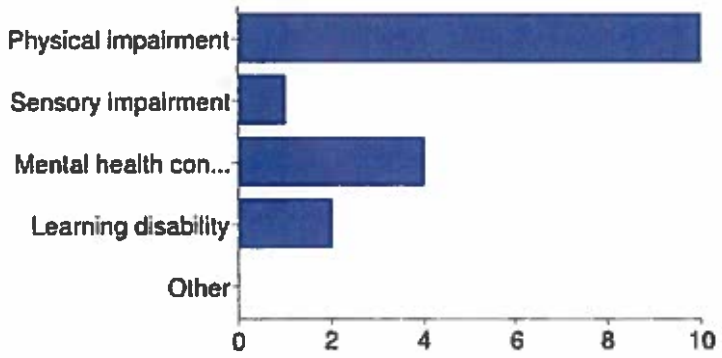
Under 16	**0**	0%
16 - 24	**7**	11%
25 - 34	**12**	19%
35 - 44	**14**	23%
45 - 54	**7**	11%
55 - 64	**13**	21%
65 - 74	**2**	3%
75+	**5**	8%

Do you consider yourself to have a disability?



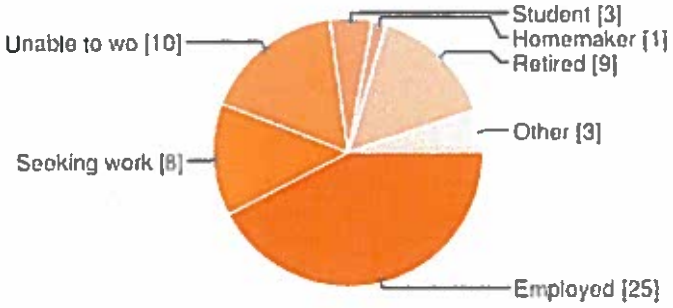
Yes	**15**	24%
No	**45**	73%

If you have answered yes, please specify:



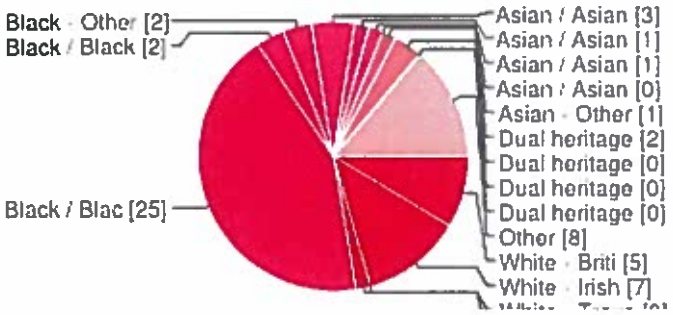
Physical impairment	**10**	16%
Sensory impairment	**1**	2%
Mental health condition	**4**	6%
Learning disability	**2**	3%
Other	**0**	0%

Employment status



Employed	**25**	40%
Seeking work	**8**	13%
Unable to work	**10**	16%
Student	**3**	5%
Homemaker	**1**	2%
Retired	**9**	15%
Other	**3**	5%

Ethnic group / heritage



White - British	**5**	8%
White - Irish	**7**	11%
White - Traveller / Romany	**0**	0%
White - Eastern European	**1**	2%
Black / Black British - African	**25**	40%
Black / Black British - Caribbean	**2**	3%
Black - Other	**2**	3%
Asian / Asian British - Indian	**3**	5%
Asian / Asian British - Pakistani	**1**	2%
Asian / Asian British - Bangladeshi	**1**	2%
Asian / Asian British - Chinese	**0**	0%
Asian - Other	**1**	2%
Dual heritage - White & Black African	**2**	3%
Dual heritage - White & Black Caribbean	**0**	0%
Dual heritage - White & Asian	**0**	0%
Dual heritage - Other	**0**	0%
Other	**8**	13%

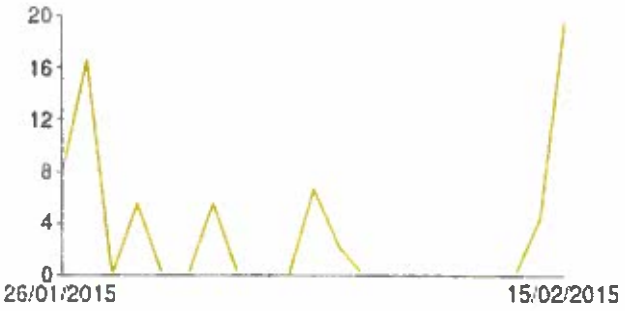
INTERNAL USE ONLY: Reference

bscr

WR

BSCR

Number of daily responses



healthwatch
Central West London

Units 25/26, The Shaftesbury Centre
85 Barlby Road
London
W10 6BN

23 February 2015

Dear Mr Mansfield QC,

Re: Healthwatch Central West London submission of evidence to the North West London Healthcare Commission

Healthwatch Central West London is the independent consumer champion for health and social care services in Hammersmith & Fulham, Kensington & Chelsea and Westminster.

Established under the Health and Social Care Act 2012, Healthwatch Central West London:

- Obtains the views of the wider community and makes those views known to decision makers
- Promotes and supports the involvement of a diverse range of people in the commissioning of local health and care services
- Makes reports and recommendations about how those services can be improved
- Provides information to the public about accessing health and care services
- Represents the views of the community and service users on Health & Wellbeing Boards
- Shares our views with and makes recommendations to Healthwatch England and the Care Quality Commission.

We currently support approximately 6,000 people who live, work or use services in the three boroughs.

For more information about our work to date, please see our annual report for 2013/2014[1].

In 2012, our patient involvement predecessor, the Hammersmith and Fulham Local Involvement Network submitted a consultation response to Shaping a healthier future[2]. In 2014 and following a further two years of research and engagement, Healthwatch Central West London updated this statement on the Shaping a healthier future programme and the recently published Imperial College

[1] http://healthwatchcwl.co.uk/wp-content/uploads/2014/06/HW-CWL-Report-Publisher-2013-14-Final-web-version2.pdf
[2] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/HFLINk-Statement-on-Shaping-210912.pdf

Healthcare NHS Trust clinical strategy. Please see this statement attached as Appendix 1.

Further to our statutory powers, the NHS Hammersmith and Fulham Clinical Commissioning Group issued a response to our statement[3].

We also attach our recent press releases in relation to the CQC inspections at Chelsea and Westminster NHS Foundation Trust (Appendix 2) and Imperial College Healthcare NHS Trust (Appendix 3), for the consideration of the North West London Healthcare Commission.

We also submit further concerns on the quality of mental health services and on maternity services that may be impacted by the 'Shaping a Healthier Future' programme (Appendix 4).

We are happy to provide any further information as required and hope that the information attached is of use to the commission.

Yours faithfully,

Christine Vigars

Christine Vigars
Chair
Healthwatch Central West London

[3] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-response-14-10-14-31.pdf

Appendix 1 - Healthwatch CWL Statement on Shaping a Healthier Future

Executive Summary

Healthwatch Central West London is the independent champion for people who use health and social care services in Hammersmith & Fulham, Kensington & Chelsea, and Westminster.

Background

Healthwatch Central West London supports the principles behind 'Shaping a healthier future,' and the vision underpinning the Imperial College Healthcare NHS Trust Clinical Strategy. We also understand the financial need for change.

This statement, and the questions it raises, has been produced following consultation with patient and service users across the three Boroughs, and is in response to the 'Shaping a Healthier Future' programme, and the 'Imperial College Trust Clinical Strategy', both of which have been presented to Healthwatch Central West London for consideration and comment.

Recommendation:

Healthwatch Central West London recommends strongly that no further progress on either project be undertaken until responses have been provided to the questions and concerns raised in our report.

Specific areas of concern:

Patient and public engagement

- We have concerns about the accessibility, effectiveness, reach, and clarity of purpose of the current engagement approaches for both projects.

Out of hospital strategy

- We have concerns regarding a number of key issues:
  - How will the success of out of hospital services be measured and evaluated?

  - What local arrangement will be put in place to support the development of community pharmacy services, to underpin the overall aims of strategy?
- We would also like to see further detail on how the strategy will address the needs of children and young people.

Urgent Care Centre at Hammersmith Hospital

- We would like more details on staffing levels for the centre.
- We would like more detail on how quality of care will be monitored and evaluated.

Paediatric Services

- We would like more information about the rationale for offering paediatric care at the Urgent Care Centre.

Impact of A&E closures on other services

- We would like assurance that adequate consideration has been given to the numbers of staff and beds that will be available at St Mary's Hospital to cope with any increase in demand
- We would like assurance that the proposals will not exacerbate the existing problem of breaches of the 30 minutes LAS handover target.

Future of Charing Cross Hospital A&E Department

- We would like further detail on the specifics of the emergency services that will be available at the department under SAHF.

Hyper acute stroke unit and elective orthopaedic services

- We would like more detail on how patient transport and patient pathways will be improved to support the proposal for a centralised HASU.
- We would like to see further public engagement be undertaken on the proposals to develop a centralised model of elective orthopaedic service a Central Middlesex.

Travel, transfers, and patient choice

- We would like to see plans to improve patient transport provision.
- We would like to see more detail on how the plans will support the development of patient pathways and improve patient choice.

Healthwatch Central West London statement on the "Shaping a healthier future" programme and the Imperial Clinical Strategy

1. Introduction

1.1. Local Healthwatch were brought in to statute via the Health and Social Care Act 2012 to give residents and communities a strong voice in shaping how their health and social care services are provided. Healthwatch Central West London represents over 5000 people and voluntary groups in Hammersmith and Fulham, Kensington and Chelsea and Westminster.

1.2. The North West London NHS (NWL NHS) initiative 'Shaping a healthier future' (SaHF)[4] aims to provide greater care in the community and rationalise usage of secondary care. The initiative includes the reduction of major hospitals in North West London from nine to five.

Healthwatch Central West London supports the principles behind 'Shaping a healthier future,' and the vision underpinning the Imperial College Healthcare NHS Trust Clinical Strategy. We also understand the financial need for change.

1.3. Healthwatch Central West London is represented on the:
- North West London Patient Public Reference Group (PPRG) to NWL NHS
- NWL NHS Transport Advisory Group (TAG)
- Imperial College NHS Trust SaHF Programme Board and the
- NWL NHS Outline Business Case (OBC) working groups.

2. Patient /public engagement (2013 to date)

2.1 Our predecessor, Hammersmith and Fulham LINk issued a statement[5] in response to shaping a healthier future in 2012. This included our concerns about the quality of patient information and engagement at that time.

2.2 Further to our views in 2012 and our work on the PPRG to date, we continue to have outstanding concerns around the quality of patient and public engagement from the SaHF team. For example, events in the autumn of 2013 to design Charing

[4] http://www.healthiernorthwestlondon.nhs.uk/
[5] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/HFLINkStatementSaHF081212.pdf

Cross Hospital, patients, their representatives and the voluntary sector raised the following concerns:

a) Accessibility - Feedback from local people participating in the 'interactive design workshop' found the information was presented in a confusing and inaccessible format.
b) Effectiveness - Local residents tell us they are utterly confused about what services will and/or will not be available at Charing Cross Hospital especially the about what form (if any) the A&E will take.
c) Reach - The engagement is limited in its reach and it is not coordinated. Attendance at the SaHF outreach and drop in sessions is low. The NWL engagement does not seem to link to Clinical Commissioning Group, NHS trust, NHS England nor local authority engagement strategies suggesting fragmentation in communicating integrated service delivery.
d) Clarity - We remain unsure of the exact purpose of the engagement. Initial feedback from patients and the public suggests there has been a focus on sharing information with public/patients. However we note that recommendation 12 of the IRP[6] review states: *"The NHS must use the next period to achieve a shift in approach from communicating what they are doing to involving and engaging people in the challenge of improving services through co-design, evaluation and change"*
e) Effectiveness - Poor communication, confusion and a lack of confidence is compounded by NHS NWL staff and representatives leading engagement sessions without sufficient information on the actual need for change and the readiness of our of hospital infrastructure. This is not the Healthwatch understanding of patient co-production, engagement or information. Research demonstrates that if people do not have confidence and trust in their health services they will not optimize their usage.

2.3. Healthwatch Central West London welcomes the publication of the Imperial clinical strategy. We note the staff engagement that has been conducted to date; we would welcome further engagement from ICHT and SaHF on the latest plans for Charing Cross Hospital and would be committed to working with them to support this.

3. Out of Hospital Strategy

3.1 Healthwatch Central West London continues to believe that the Out of Hospital strategy is the lynchpin for the successful implementation of 'Shaping a healthier future' and the Imperial Clinical Strategy. Whilst Healthwatch very much welcomes this initiative, there are still concerns that indicators of success and safeguards to protect patient safety and outcomes are not in place. This is particularly important from September when the A&E at Hammersmith Hospital will close. We are not clear how the services that have moved out of hospital in the last two years are performing. We would be interested in hearing from NHS

[6] http://www.irpanel.org.uk/lib/doc/000%20Inw%20report%2013.09.13.pdf

HFCCG and NWL NHS on the current performance of the services that have moved out of hospital to date and the capability of OOH services to meet future need.

3.2 As GPs are expected to be at the heart of all NHS reform, the NHS Hammersmith and Fulham Clinical Commissioning Group must be unified, equipped and enthusiastic about taking on this new management role. GP support to reduce waiting times, enhance patient satisfaction and promote accessible local options for health and well-being is essential in keeping people out of hospital. Further to patient feedback, Healthwatch would welcome further information on support for these changes from primary care practitioners. Furthermore how will the quality assurance of primary care services be monitored locally?

3.3 The successful implementation of this strategy will require the effective integration of health and social services. The full support of the London Borough of Hammersmith and Fulham, the Royal Borough of Kensington and Chelsea and Westminster City Council in this period of austerity is essential for the roll-out of any new 'Shaping' initiative. Healthwatch welcomes the role of the Health and Well-being Boards in supporting joint commissioning decision-making. Healthwatch would also emphasize the opportunities for joint working on out of hospital service provision, the Whole Systems Integrated Care Programme and the Better Care Fund.

3.4 Healthwatch remains unclear as to how the cultural shift required to implement these proposals will be achieved. For example, how will 'hard to reach' and more 'vulnerable' groups be supported to understand the new '111' phone line, urgent care services and thus prevent the exacerbation of health inequalities? Our local research shows[7] that in spite of a national campaign on NHS 111, only 40% of local people are aware of it. In the absence of clear evidence and need for change local people are confused and becoming increasingly frustrated.

3.5 Healthwatch is concerned about the implications of the Out Of Hospital programme for medication management. Our research shows hospital pharmacies are already struggling with patients waiting for hours for medication on discharge[8]. Healthwatch recognizes that NHS England commissions community pharmacy services; however it would be helpful to know how SaHF and local CCGs will work with NHS England to ensure that community pharmacy provision supports the OOHH program, especially on the following points. Will there be an increased and more diverse demand for community pharmacy services? If so, will extra resources be available to meet demand? Will extra resources be made available to support the home delivery of medication to patients as required? How are pharmacies engaged and how will the quality assurance of these services be monitored locally?

3.6 Healthwatch is also seeking further information on how out of hours services link to the Out Of Hospital programme and support the delivery of the wider SaHF program, we would be particularly keen on understanding how the quality assurance of urgent care centres will work.

---

[7] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Use-Of-Services-Report-FINAL.pdf
[8] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-CWL-RBKCDischarge.pdf

3.7 Healthwatch would also like further clarification on how the out of hospital strategy is addressing the needs of children and young people, especially as there is a lack of focus on children and young people in the Whole Systems Integrated Care Programme and the Better Care Fund initiatives.

3.8 Healthwatch Central West London notes with concern that patients returning from hospitals outside our boroughs are having difficulties accessing discharge pathways.

4. Opening hours of the Urgent Care Centre (UCC) at Hammersmith Hospital

4.1. NHS HFCCG has committed to ensuring the UCC replacing the A&E at Hammersmith Hospital will be open and staffed 24/7. We would like further detail on the medium-longer term plans for the hours of operation at this UCC. It is hoped the existing triage system will be expanded to prevent excessive waiting times and that local residents and patients will have accurate information about where to access 24 hour urgent care. How will the UCC contract be monitored?

5. Paediatric services

5.1 Healthwatch has concerns over paediatric expertise in the community; especially with the closure of A&Es. Key communications about the change from A&E to UCC coverage suggests the UCC will be an appropriate place to take children. However it is unclear whether the GPs at Hammersmith Hospital UCC will have the required paediatric expertise to see these patients. We understand that this has been addressed in H&FCCG board meetings, but would encourage this information to be shared more widely.

5.2. In addition our recent research has indicated that parents with young children are more likely to attend A&E than primary care settings.[9]

5.3 We are seeking clarification on the appropriateness of Hammersmith Hospital UCC for children and how appropriate pathways are being communicated to parents. How will patient education be measured to ensure children are accessing appropriate services?

5.4 Healthwatch is also seeking clarification on the performance of the "Connecting for Care" pilot and how lessons learned will inform available urgent and community care paediatric services.

5.5 As stated in 3.8, we are not clear how the needs of children and young people are being planned for under Whole Systems and the Better Care Fund.

6. Impact of A&E closures on other services

[9] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Use-Of-Services-Report-FINAL.pdf

6.1 Healthwatch is seeking full assurance that the A&E departments at St Mary's and Chelsea and Westminster Hospitals will have sufficient resources to cope with the additional capacity likely to result from the closure of local A&E departments and changing demographics.

6.2 Healthwatch is also concerned that planning is not joined up. For example, the 'sudden' potential closure of two GP practices, Milne House and West 2, near to St Mary's Hospital may mean patients are dispersed and de-registered from a GP and/or a GP they trust. Recent national research[10] has shown the importance of trust when living in the community and our local research identified the poor availability of GP services as the prime reason for patients inappropriately accessing A&E.

6.3 Healthwatch is concerned staffing and bed numbers at St Mary's A&E are not at required levels. We would seek assurance that steps are being taken to ensure adequate, qualified staffing levels (not temporary staff) and bed numbers to support the Imperial clinical strategy.

6.4 We note a number of our local A&Es have recorded breaches of the 30 minute LAS handover target in recent months. We are concerned that the closure of the A&E departments at Hammersmith Hospital (and probably at Charing Cross Hospital) will further exacerbate the problem. We are seeking assurance that measures are in place to prevent further breaches at all local hospitals, to ensure adequate staffing in LAS now but also to future proof for further changes to our local hospitals.

6.5 Healthwatch has reviewed the proposed engagement and communication plan around the closure of A&E departments at Hammersmith Hospital and Central Middlesex Hospital and is re-stating the following:

- The stated objectives include an aim to "ensure understanding that 24/7 UCCs remain on site." We believe this must include ensuring local people understand the nature of UCC services; the specification for a local UCC needs to be communicated.
- One of the stated key messages is to ensure "the majority of people who go there now for urgent treatment of minor injuries and illnesses will continue to do so." We believe this message needs to be more specific so the public understands clearly when UCC services at Hammersmith Hospital are appropriate. Our recent research[11] indicated 59% of local people were unaware of the term Urgent Care Centre, and what services it provides.
- We want to ensure patients and their representatives are fully involved in the design of key communications. Although patient reps were involved in focus groups, the final leaflet was not that agreed in the focus groups our representatives attended. A final draft of the agreed leaflet was not shared to 'close the loop' on the 'consultation.'

[10] http://www.kent.ac.uk/sspssr/research/centres/trust-healthcare.html
[11] http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Use-Of-Services-Report-FINAL.pdf

- Healthwatch Central West London would like to know how the impact of the engagement and communication on patient education will be measured.

7. The future of the Charing Cross Hospital Accident & Emergency Department

7.1 Healthwatch notes the Secretary of State for Health (October 2013) stated that an A&E service should remain at Charing Cross Hospital.[12] We also note the recent clinical strategy published by Imperial College Healthcare NHS Trust states that Charing Cross Hospital will have an "Emergency Centre"[13]
The publication and likely impact of the urgent care review therefore seems to be poorly timed. In considering the changes proposed by the clinical strategy, Healthwatch is not clear on how an emergency service/A&E could be safely supported on the Charing Cross site.

7.2 We are concerned that current public and media messaging concerning the future of local A&E departments is not clear and could be misleading for patients. We are seeking clarity on and look forward to co-producing the service specification for Charing Cross Hospital.

8. Hyper Acute Stroke Unit (HASU), Maternity services & Elective Orthopaedic Services

8.1 We understand the clinical case supports co-locating specialties on one super site. This should mean moving the HASU to the same site as related support services leads to better clinical and patient outcomes for users. However, local residents and patients are worried about the new pathways. It is not clear where patients will access pathways and where follow-up appointments will be provided. Patient transport is a real concern for Imperial patients and travelling to St Mary's will result in increased travel times, congestion charges and reduced accessibility. Local residents and patients need more information on stroke pathways including the potential increase in travel times and any impact on clinical and patient outcomes. We would also like details of all the HASUs across North West and central London.
How will patient choice be supported?

8.2 Healthwatch notes that ICHT has given assurances that the HASU will not move to St Mary's Hospital until after major re-development of the St Mary's site has taken place, will SaHF also give assurances that this is the case and ensure that the move does not take place beforehand.

8.3 Healthwatch has recently seen fully developed proposals for the new centralized elective orthopaedic service at Central Middlesex Hospital.

---

[12] http://www.theyworkforyou.com/debate/?id=2013-10-30b.921.1
[13] http://www.imperial.nhs.uk/prdcons/groups/public/@corporate/@communications/documents/doc/id_045151.pdf

8.4 Healthwatch would welcome the opportunity to engage on these proposals, particularly around the following areas of concern:

- Why have these proposals not been mentioned previously?
- We understand that (as with proposals to move the Hyper Acute Stroke Unit) co-locating specialties is the key to maintaining and raising clinical standards. Will Central Middlesex Hospital have the required level of staffing, expertise, related support services and specialties to support elective orthopaedic patients?
- How will the pathway in to and out of Central Middlesex work?
- What will the staffing profile be?
- How will the quality of patient transport services be improved?
- Will social, community and voluntary services be co-located to arrange suitable supports for people on discharge?
- Healthwatch understands that consultants will meet with patients at local hospitals. Will consultants be based at local hospitals or at Central Middlesex Hospital and be expected to travel? How will this travel impact on clinical time consultants have available?

8.5 Healthwatch is aware of proposals for the reconfiguration of maternity services in NW London, Healthwatch is also aware that a new central booking service is proposed for maternity services in NW London, Healthwatch would welcome the opportunity to engage on these proposals, and urges that consultation would occur across NW London and not just in the London Borough of Ealing.

9. Travel, transfers & patient choice

9.1. Under the current plans a significant number of local residents will have to travel to St Mary's or Chelsea and Westminster to access a full 'A&E' department. Healthwatch has received a number of concerns from our members about the accessibility of transport options and proposed transport times to St Mary's especially for disabled people; we remain unclear on how these concerns will be addressed. Healthwatch wishes to engage with NWL NHS and NHS HFCCG and community networks to identify transport solutions and information for equality groups. To facilitate this we would also welcome public updates from the SaHF TAG.

9.2. Healthwatch is concerned about patient experience of the local hospital transport service, our research indicates that patients already need to wait for long periods and describe the service as erratic,[14] [15] In light of potential greater use of this service caused by SaHF future changes would be interested to hear from NWL NHS and HFCCG on how they plan to improve this service.

9.3. Healthwatch is keen to ensure that longer 'blue light' travel times do not impact negatively on the quality of the emergency service provided to patients. Training,

[14] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/CharingCrossdignitydischargereportFinal.pdf
[15] http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Dignity-and-Discharge-at-Chelsea-and-Westminster-Hospital-Nov-2013.pdf

resources and systems must in place before any changes are made to secondary care provision.

9.4 We are not clear how the proposed pathways support patient choice. For example, the Heart Hospital currently located in Westminster is due to move 'out of cluster.' The vast majority of Westminster patients are currently sign-posted to Hammersmith Hospital over the hospital in their borough. How will patients be supported to access local services over commissioned pathways?

10. Conclusion

10.1 Healthwatch is of the firm belief that there is no point in developing proposals for the NHS if it is creating results that patients don't want. Healthwatch is concerned about the overall confusion surrounding the shaping proposals. There is a lack of clear information and education for the public and patients on the need for change and on the proposals that will occur under shaping a healthier future. Current 'engagement' is not meeting the needs of local people. Key behavioural patterns are not being considered and changes are being imposed as opposed to being co-produced. We know trust and access are key factors in patients using services effectively and staying healthy at home. Changes are happening now yet information around UCCs, patient pathways, integrated service delivery, robust out of hospital service delivery and wider supports such as travel & access points are not available for local people. Healthwatch hopes that lessons are learnt from the mistakes of past engagement to ensure future engagement better meets local need.

11. Recommendations

Recommendations for SaHF and local CCGs

- The key messages for the need for change must be clearer, reframed and co-produced i.e. based on the financial and clinical cases.
- Clear information about the UCCs in Hammersmith and in neighbouring boroughs needs to be clearly communicated. People do not think about borough boundaries when accessing services.
- Clear information and opportunities to engage on the proposed elective orthopaedic services at Central Middlesex hospital should be made available immediately alongside the proposed patient pathway to enable co-production.
- Information on appropriate services for primary, urgent and emergency paediatric care should be made available to parents / carers. Community alternatives must be co-produced and based on patient as well as clinical outcomes.
- There needs to be engagement to develop quality transport options to community services, Charing Cross, St Mary's Hospital and Chelsea and Westminster Hospitals.
- Alternative pathways to A&E should be promoted and communicated to residents, including 7 day GP access, out of hours, walk in centres,

Urgent Care Centres and NHS 111. A one stop shop to accessing appropriate services could be a key part of this.

- The programme needs to take on the clear learning available from previous NHS patient campaigns on walk in centres, NHS 111 etc.
- The SaHF programme needs to ensure that all communication is accurate, accessible (including for people with learning disabilities and visual impairments), and clear.
- Patient education on the new pathways needs to be built in to current service delivery and associated programmes such as expert patient, navigators and health trainers.
- The role for the wider community sector in delivering out of hospital services needs to be co-produced.

Recommendations for ICHT

- There needs to be effective, joined up patient engagement on the Imperial Clinical Strategy.

Recommendations for both SaHF and ICHT

- Ongoing engagement around Charing Cross Hospital must be clear in its purpose. This includes information sharing, engagement and co-production and patient education, for example, referring to the "ladder of participation"[16]
- The future plans for 'emergency services' at Charing Cross Hospital should be made available now.
- Clear information on the impact of the movement of the Hyper Acute Stroke Unit from Charing Cross Hospital to St Mary's Hospital on clinical and patient outcomes should be made available. The proposed pathway for stroke patients including the pros and cons should underpin this.

Christine Vigars
Chair
Healthwatch Central West London

Units 25/26, The Shaftesbury Centre
85 Barlby Road
W10 6BN
02089687049
healthwatchcwl@hestia.org

[16] http://lithgow-schmidt.dk/sherry-arnstein/ladder-of-citizen-participation.html

Appendix 2: Healthwatch press release (Chelsea and Westminster)

Healthwatch Central West London Expresses Concerns Following Care Quality Commission Announcement on Chelsea and Westminster Hospital NHS Foundation Trust

Healthwatch Central West London has expressed concern following an inspection by the Care Quality Commission (CQC) into the standard of care by Chelsea and Westminster Hospital NHS Foundation Trust.

The CQC rated the Trust as "Requires Improvement Overall" – though some services were rated as good or outstanding. The full reports on the trust and on the hospital are available from: http://www.cqc.org.uk/location/RQM01.

Healthwatch empowers local people to put concerns to health and social care service providers helping them to improve the care that is given. We engage with the Chelsea and Westminster Hospital NHS Foundation Trust on an ongoing basis over the care being provided and supplied evidence to inform the CQC inspection.

London based charity, Hestia, operates the Central West London Healthwatch contract covering Hammersmith & Fulham, Kensington & Chelsea and Westminster.

Paula Murphy, Director of Healthwatch, Central West London said:

"Healthwatch gives people a powerful voice, helping patients get the best out of their local health and social care services. Over recent months we've been actively working with the Chelsea and Westminster NHS Foundation Trust and the CQC, in order that care can be monitored and improved.

We are concerned at the announcement made by the Care Quality Commission today, but we will continue to work with patients to ensure they get the best treatment and support possible. At a time of financial pressures on the NHS, we want to protect the quality of our local services. It is not acceptable for the funding gap, combined with significant local service re-configuration, to lead to a divide between service capacity and our patient needs. Quality and safety of care must be paramount at all times.

We champion the voice of the people on health and social care services – and we know that patients, and staff, deserve better. We'll continue to communicate constructively and positively with the Foundation Trust, and with local commissioners, to ensure practical improvements and systematic supports are taken on board."

Notes to Editors:

Hestia began operating the Healthwatch contract in Central West London in April 2013.

Below is a list of statements Healthwatch has made regarding care at Chelsea and Westminster Hospital NHS Foundation Trust since taking over the contract:

- QA statement 2013/14: http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Chelsea-Westminister-HW-Response-QA-2013-14-Final.pdf

- Chelsea and Westminster paediatrics unit: http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/ChelWest-Paed1.pdf; child friendly version: http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/ChelWest-child-friendly1.pdf

- Response to Chelsea and Westminster paediatrics: http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Chelsea-and-Westminster-Paediatric-Response-Jan-2014FINAL1.pdf

- Chelsea and Westminster dignity and discharge: http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Dignity-and-Discharge-at-Chelsea-and-Westminster-Hospital-Nov-2013.pdf

- Chelsea and Westminster response on transport/discharge: http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Action-Plan-Transport-Lounge-healthwatch-nov-13-3.pdf

- Chelsea and Westminster response re David Evans: http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Action-Plan-David-Evans-healthwatch-nov-13.pdf

➢ Healthwatch statement on Shaping a healthier future:

http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-statement-FINAL.pdf
Healthwatch has also made verbal representations on behalf of patients concerning:

- London Ambulance Service handovers – 30 minute breaches
- 8 week Referral To Treatment (speciality)
- Statutory Instrument reporting
- Discharge data capture
- Patient pathways to community and primary care
- Medication
- Choose and book compliance, appointments service and waiting times
- Maternity
- Cancer

For more information, please contact Paula Murphy, Director, Healthwatch Central West London on 07967 225 015 or at Paula.Murphy@hestia.org

Appendix 3: Healthwatch press release (Imperial)

Healthwatch Central West London Expresses Concerns Following Care Quality Commission Announcement on Imperial College Healthcare NHS Trust

Healthwatch Central West London has expressed concern following an inspection by the Care Quality Commission (CQC) into the standard of care provided by Imperial College Healthcare NHS Trust.

Christine Vigars, Chair of Healthwatch Central West London said:

"Healthwatch has developed a positive working relationship with the new directorate and recognise their commitment to multi-disciplinary working. We are pleased the recent CQC inspection found clinical outcomes for patients were good.

"However, at a time of some confusion around Urgent Care and A&E usage locally, we are concerned about the reported variability in local performance. We would welcome a joined-up approach to engaging and communicating with patients.

"We are also seeking assurance about the steps being taken to ensure adequate, qualified staffing levels."

The CQC rated the Trust as 'Requires Improvement Overall' – though some services were rated as good or outstanding. The full reports on the trust and on the hospital are available from:
http://www.cqc.org.uk/provider/RYJ

Healthwatch empowers local people, patient groups and their representatives to put concerns to health and social care service providers helping them to improve the care that is given. We engage with Imperial College Healthcare NHS Trust on an ongoing basis over the quality of care being provided and submitted our evidence to the CQC inspection.

Paula Murphy, Director of Healthwatch, Central West London said:

"Healthwatch gives people a powerful voice, helping patients get the best out of their local health and social care services. Over recent years

we've been actively working with Imperial College Healthcare NHS Trust and the CQC, in order that care can be monitored and improved.

"We are most concerned at the announcement made by the Care Quality Commission today, and we will continue to work with patients to ensure they get the best treatment and support possible. At a time of financial pressures on the NHS and on social care, we want to protect the quality of our local services. It is not acceptable for the funding gap, combined with significant local service re-configuration, to lead to a divide between service capacity and our patient needs. Quality and safety of care must be paramount at all times.

"In October 2012[17], patients clearly stated the successful implementation of 'out of hospital' services is the essential building block, which must be in place and effective before any reduction of current hospital services. Two years on, we are increasingly concerned about the absence of a primary care strategy, the de-investment in social care and the under-recruitment of staff. Not only does this raise the health risks of those in the community but recent CQC inspections of our A&Es seem to suggest it is also distracting attention from essential hospital care provision.

"With plans to move many more services out of hospital, we strongly recommend that no further progress on shifting services is undertaken until responses have been provided to the questions and concerns raised in recent CQC reports on local A&E and outpatient care.

"We champion the voice of the people on health and social care services – and we know that patients, and staff, deserve better. We'll continue to communicate constructively and positively with the Trust, and with local commissioners, but we are seeking additional information on the safeguards and key indicators of success in the Out of Hospital (OOH) strategy to ensure patient safety at this time of change."

Notes to Editors:

Established under the auspices of the Health and Social Care Act 2012, Healthwatch is the independent consumer champion covering Hammersmith & Fulham, Kensington & Chelsea and Westminster. London based charity, Hestia, began operating the Healthwatch contract

[17] http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/KCLINkStatementSAHF081012.doc.pdf

in Central West London in April 2013.
Please see www.healthwatchcwl.co.uk for further information.

Below is a list of statements Healthwatch (and our predecessor the Local Involvement Networks) have made regarding care at Imperial College Healthcare NHS Trust since taking over the contract:

- Healthwatch statement on Shaping a Healthier Future 2014: http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-statement-FINAL.pdf

- Quality Account Statement 2013/14: http://healthwatchcwl.co.uk/wp-content/uploads/2013/09/Imperial-QA-2013-14-Final.pdf

- Healthwatch report on Hammersmith Hospital: http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-CWL-DC-assessment-of-Hammersmith-Hospital.pdf

- Healthwatch report on hospital discharge (summary): http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Healthwatch-CWL-RBKCDischarge.pdf

- Healthwatch report on cancer patient experience in Charing Cross http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/Charing-CrossCancerReport.pdf

- Healthwatch report on use of primary and urgent care services in H&F http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/Use-Of-Services-Report-FINAL.pdf

- Healthwatch on 'Working in Partnership,' the Imperial College Healthcare NHS Trust application for foundation trust status http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/ImperialConsultationResponseHealthwatchCWL100214Final.pdf

- Healthwatch report on dignity on the wards in St Mary's Hospital: http://healthwatchcwl.co.uk/wp-content/uploads/2014/01/St-Marys-report-August.pdf

- H&F LINk on Dignity and Discharge in Charing Cross
http://healthwatchcwl.co.uk/wp-content/uploads/2014/03/CharingCrossdignitydischargereportFinal.pdf

Healthwatch has also made verbal representations on behalf of patients concerning:

- London Ambulance Service handovers – 30 minute breaches
- 8 week Referral To Treatment
- Discharge data capture
- Patient pathways to community and primary care
- Medication
- Choose and book compliance, appointments service and waiting times
- Cancer
- Disability access

For more information, please contact Paula Murphy, Director, Healthwatch Central West London on 07967 225 015 or at Paula.Murphy@hestia.org

Appendix 4: Other Healthwatch concerns (maternity and mental health)

1. Maternity Services

1.1 We are concerned about the impact, of the proposed transition of maternity services from Ealing hospital to neighbouring hospitals, on the quality of maternity services delivered at Queen Charlotte's and Chelsea Hospital and at Chelsea and Westminster Hospital.

1.2 Healthwatch believes that more thought should be given to the modelling of where patients from Ealing will choose to access maternity services, to ensure that enough capacity can be provided at all sites.

1.3 Healthwatch believes that SaHF should ensure that the correct levels of qualified midwifery and consultancy cover are available at all sites. Healthwatch is particularly concerned about the level of consultant coverage at Queen Charlotte's and Chelsea and whether the correct level will be in place in time for the transition from Ealing.

1.4 Healthwatch is unclear on what steps have been taken to ensure that residents from Hammersmith & Fulham and Kensington & Chelsea will not be disadvantaged by increased numbers of patients from Ealing accessing services in Hammersmith & Fulham and Kensington & Chelsea.

1.5 We are also unclear about what impact the Chelsea and Westminster Hospital NHS Foundation Trust proposals to takeover West Middlesex will have on future modelling.

2. Mental Health Services

2.1 Healthwatch is concerned about the potential for disruption and loss of mental health services located at the Charing Cross Hospital site under the SaHF proposals.

2.2 Healthwatch believes it is unclear whether the proposed changes at Charing Cross Hospital will allow for the retention of the current mental health inpatient unit and outpatient service.

2.3 Healthwatch is particularly concerned as inpatient beds at this unit are currently being reduced resulting in a higher likelihood of Hammersmith and Fulham residents being placed out of borough, something local patients have highlighted as a major concern for them.

2.4 Healthwatch is concerned that the pathway for people with mental health needs presenting at local A&E and urgent care centres remain unclear.

Smith Peter

From: Sandhu Ajaib (NHS EALING CCG) <ajaibsandhu@nhs.net>
Sent: 24 February 2015 18:55
To: Smith Peter
Cc: eveturner@btopenworld.com
Subject: North West London Healthcare Commission- Call foe Evidence

With reference to the above subject matter , I wish to make the following statement for the attention of Sir Michael Mansfield QC, Chair: North West London Healthcare Commission.

As a General Medical Practitioner , I have been involved for over forty years , in the provision of Primary Care Services both within the London Borough of Ealing (Southall) and the London Borough of Hounslow (Chiswick). In Chiswick , I have served the affluent community and in Southall I have and still am serving the Southall's multi-ethnic community population of 6,000 residents served by the Ealing Hospital since 15th July 1998 by providing General Medical Services from the Belmont Medical Centre .

In addition , as a Founder Trustee of **SHIP** (**S**outhall **H**ealth **I**mprovement **P**rogramme) registered charity , I am the Founder Trustee and the Clinical Lead for SHIP , recruiting volunteers / paid skills for providing these services from 'outreach' sessions at all Faiths organisations for the last 25 years.

In 2004 , when the Quality Outcomes Framework was introduced , services provided by BM Centre were outstanding in that the Practice's achievements were higher than those set by the QOF targets , thus Belmont Medical Centre was labelled as 'Best Practice' and as recently as the 13th October 2014 , I was called upon to give a talk at the Royal College of Physicians about the 'Best Practice' Belmont Medical Centre had achieved .

Since 1998 , working as 'solo' Practitioner , first the BMC was computerised and thereafter 12-14 hours a day input was conducted first by myself and now , is maintained by , Partner and long term locum doctors .

Though at the QOF Assessments , every three years x twice , I was asked the question, why is your Cardio-vascular incidence so low as well as why is your stroke incidence so low.The answer to both these questions was , ' Best Practice ' provision.
Now , I come to answer the main query about the Ealing Hospital's proposed closure :I have conducted a Practice staff enquiry into this question and the answers provided both by Clinicians and non-clinicians is as follow:

- Residents served by Ealing Hospital have the benefit of the proximity of services provided therein.
- Easy Access by single bus route lasting not more than ten-15 minutes to or fro.
- Shorter journeys for the ambulance services frequently sirens screaming for blue light ambulances about six times daily transporting patients with chest pain (heart attacks).
- Local residents are used to the Ealing Hospital services and are appreciative of the care provided therein.
- Health statistics conducted a few years ago , revealed that Ealing Hospital has the highest emergency attendences nationally.
- Reason for this is that Inverse Care Law (short comings in care provision demands being unmet) has always been there in providing the poorer services than needed by the ethnic community that has the highest number of elderly patients , co-morbidities , obesity , diabetes Type 2 with all its complications (stroke , cardio-vascular diseases, dialysis , going blind and amputation from Peripheral Vascular Disease as well as the cancer incidences particularly 'breast cancer'.
- The last Clinical Governance of the last Primary Care Trust (Ursular Gallagher) stated in one of her lectures that as one walks down the Uxbridge Road, the doom and gloom shadows become wider and wider , as one approaches Southall.
- Ealing Hospital is a 'multicultural' hospital providing culturally sensitive services in the preferred languages.
- Ealing Hospital not only serves the residents of Southall ; it also servis the residents of Greenford , Hanwell , Ealing Common, some residents who have moved out of the area towards Hillingdon Hospital and Hounslow , still prefer to attend Ealing Hospital.
- Ealing Hospital is the 'hub' for clinical experties who coduct educational events from Ealing Hospitals and GP attendence rate to these events is usually high . The Professional Development Plans are necessary for conducting yearly appraisal for GPs to maintain Quality Care Provision.
- Local Specialist know local General Practitioners that lead to better care as well as understanding of the local community's needs.
- Ealing Hospital serves the multi-ethnicity culturally sensitive care in the patient's preferred language.

- With Ealing Hospital Closure the unemployment levels will be reflected upon.
- The several charities conducting sharity stalls on Ealing Hospital with part contribution of the income to the hospital funds as well as the charities will be affected in the adverse.

Patients attending the Practice on the day were also consulted and all were in favour of reasons given above (nearer to home ; shorter / single bus route , shorter route for Out patients' Attendences or visiting family members hospitalised ; shorter ambulance route .

Closure of Ealing Hospital will be devastating for the local residents . Its closure without alternative constructive choices locally shall be CRIMINAL JUSTICE so to say the least without measuring the already existing high mortality and shorter life spans that the local residents have from the co-morbidities and the cancers that the community suffers from.
It is only when one lives in Ealing Hospital's vicinity or works as a General Practitioner that one has a clearer picture of the impact that Ealing Hospital closure will bring to its residents.

Yours sincerely ,

Dr Ajaib K Sandhu
Belmont Medical Centre
18 Western Road
Southall, UB2 5DU

Tel: 020 8893 5515 Fax: 020 8867 1835

Independent Healthcare Commission for North West London

24/02/15

Dear Sirs,

I am writing to you as a Consultant in Infectious Diseases at Ealing Hospital. In November 2014, during the height of the Emergency Department (ED) crisis, I moved to work as an Acute Medicine Consultant with close liaison with the ED at Ealing Hospital.

I have concerns about the impact of ED closures in NW London, the capacity of the health care system to manage acute emergencies and the capacity of community / social services to allow for the safe discharge of complex elderly frail patients.

Background

In the way of background I include my submission to the Independent Reconfiguration Panel (IRP) and People's enquiry into London's NHS (appendix A). It has always been my firm belief that plans outlined in Shaping a Healthier Future (SAHF) have been economically driven with a view to cutting services and cost and not clinically driven to improve patient outcomes. The planned reconfigurations leave the deprived communities of Southall, Harlesden and Acton without EDs while the more affluent communities of Harrow, Paddington and Chelsea continue to have major acute hospitals serving their needs.

I also include in my submission a letter that the Consultant body of Ealing Hospital wrote to the Rt Hon. Jeremy Hunt MP on 10/02/13 (appendix B). This letter expresses the very real concerns the Ealing hospital Consultant body has about the implementation of SAHF. These were concerns we expressed and shared with local GPs, submitted to the IRP and expressed openly at public meetings and rallys. We would later discover the betrayal of our point of view when the medical director of Ealing Hospital signed a second letter to Jeremy Hunt on 22/10/13 (appendix C). This letter was submitted by SAHF at the eleventh hour of the IRP to combat the growing concerns of local clinicians and the public. Mr. Hunt referred to this letter in parliament on 30/10/13. The telegraph reported with the headline "Close A&Es to save lives, doctors urge Jeremy Hunt". This was not the view point of the Consultant body at Ealing hospital or local GPs. This was not a democratic representation of clinician's opinions. I would later discover in an article in the guardian how influential this letter was to push forward the SAHF agenda. (appendix D – highlighted paragraphs).

Similar assertions that hospital reconfigurations and ED closures would save lives were made when Lewisham hospital was under threat. I enclose the letter written by Consultants at Lewisham hospital at that time to Sir Bruce Keogh critically reviewing the evidence basis of these assertions (appendix E). An independent review by Tim Rideout, a former NHS Chief Executive considered

the proposals in SAHF to be flawed particularly with respect to the specific health needs of the borough and to whether the local health system will be able to cope with the unprecedented scale of change (appendix E1).

Nevertheless SAHF was implemented at a rate, which to front line clinicians seemed alarming. Indeed it was asserted in the letter from the medical directors that: "delays expose patients to serious risk and several of the current services are clinically and financially unsustainable." The implication being that SAHF were aware of the risks of the status quo and needed to close ED rapidly with little assessment of the potential risks this would pose to the local population.

Risks from ED closures

On 10th September 2014 the EDs at Hammersmith and Central Middx hospitals closed. Figure 1 shows the impact of these closures on the emergency department 4hour target. This target is set at 95% of patients attending an ED must be seen, treated, admitted or discharged in under 4 hours. The NW London sector saw a dramatic nose-dive in this target with Ealing Hospital and Northwick Park Hospitals frequently representing the worst performance status in the country. ED attendances did not dramatically increase in this time period. ED capacity to receive, assess, manage and if necessary admit patients had been taken out of the NW London health infrastructure with the closure of 2 EDs.

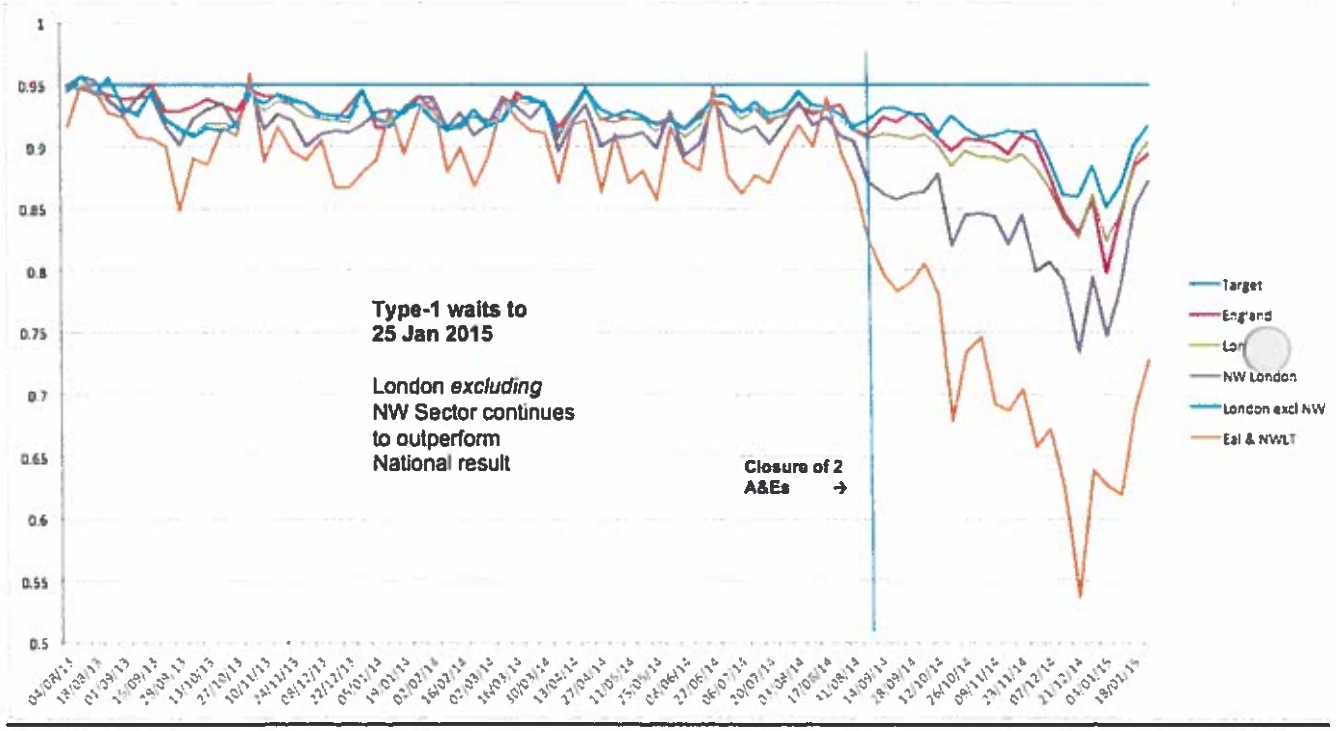


Figure 1 Percentage patients meeting ED 4hour target

Ambulance black breach data (figure2) reflect ambulance offloading times greater than 60minutes. Note data for 2014-2015 is only partial as this analysis was performed up to January 23rd 2015 whereas the previous years data is April to April. All trusts in NW London where an ED remained open saw a rise in the number of black breaches with Northwick Park hospital showing a dramatic rise in black breaches.

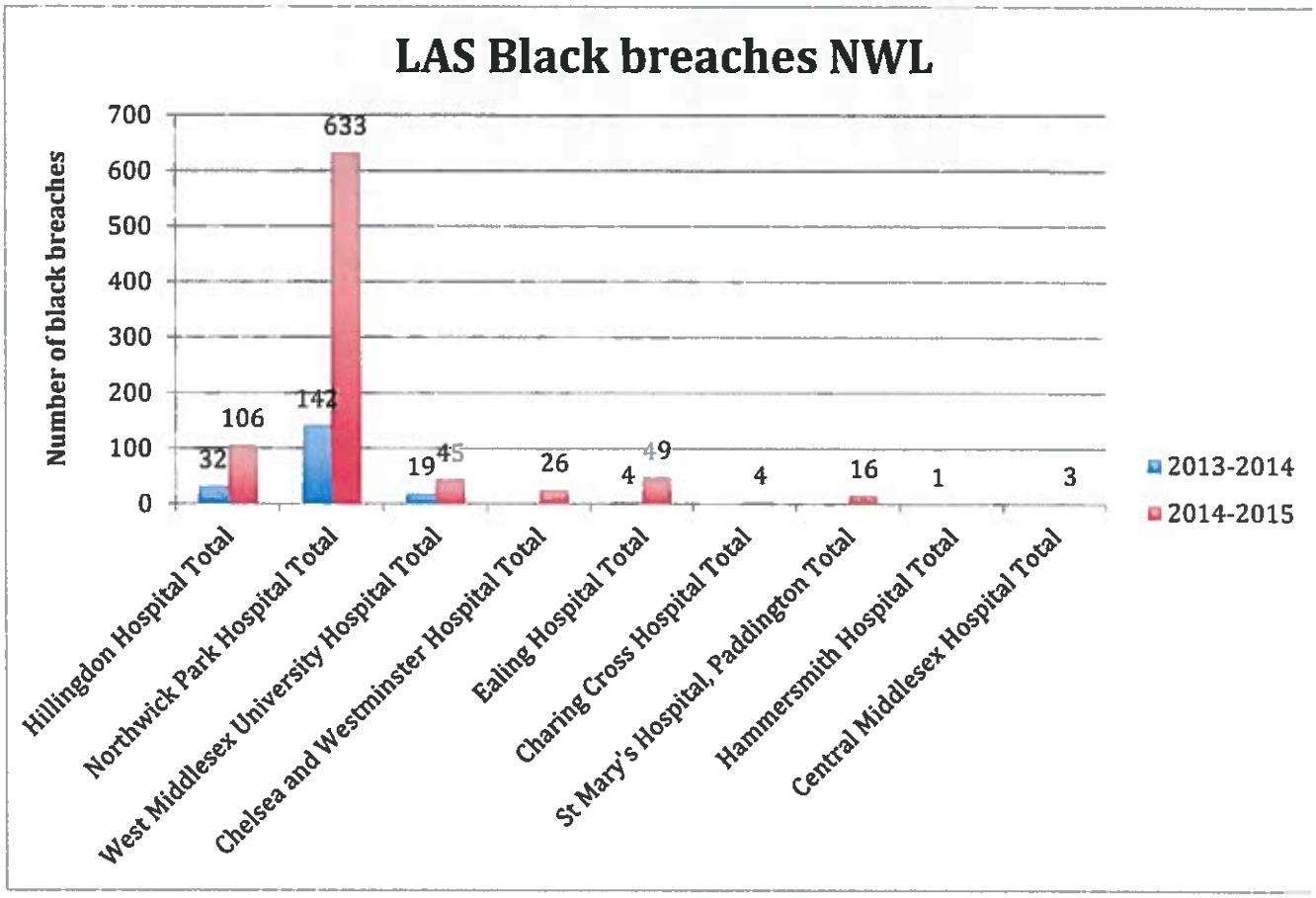


Figure 2 London ambulance service black breaches 2013/14 vs 2014/15

It would be a regular occurrence during this time period to walk into the ED as medical consultant on call and find every assessment space occupied and a resuscitation bay full of critically unwell patients, with ambulances waiting outside the hospital to offload. Intensive care beds would almost inevitably be at full capacity (Figure 3) and surgical cases would be cancelled due to lack of hospital beds. Occupancy on the ICU would be >100% with theatre recovery spaces being used for critically unwell patients.

Over the Christmas period I was in a situation where I needed to transfer a patient to John Radcliffe hospital, Oxford for lack of specialist beds and consultants in London. The clinical impression has been one of an acute infrastructure which is bursting at the seams, frequently the question would arise "where could we put an extra couple of beds in the hospital?"

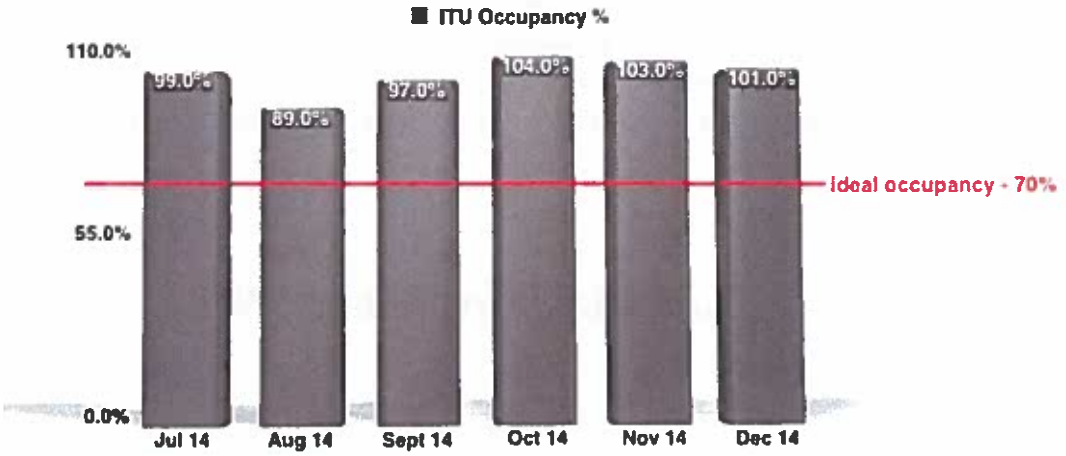


Figure 3 Ealing hospital Intensive care unit bed occupancy

Overwhelmingly it felt like we were looking after sicker patients scattered around the hospital. The National Early Warning Score (NEWS) allows for the assessment of acute illness severity. A NEWS score of greater than 7 would put patients into a high risk category. Figure 4 shows the ratio of the number of patients seen by the critical care outreach team each month with a NEWS >7 per month. For example comparing the month of July 2014 with July 2013 there were 72 calls (July2014)/ 51 calls July 2013 = 1.41. The ratios are showing an increase in the number of calls for NEWS >7, compared to the same month in the previous year. This is at a time when ITU has a high bed occupancy.

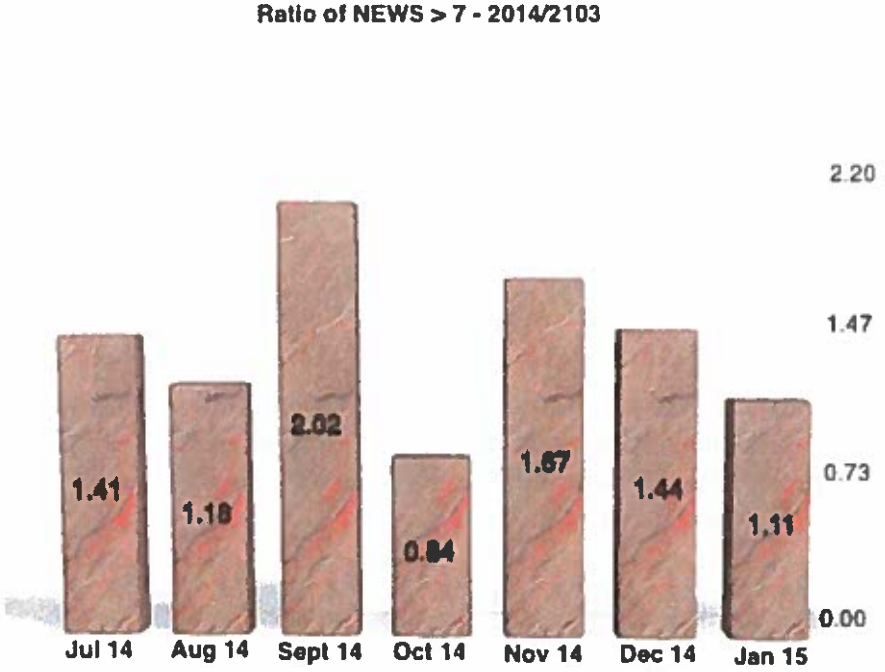


Figure 4 Ratio of number of patients seen by Critical Care Outreach team with NEWS >7 2014 / 2013

It is difficult to perceive how when combining this data together the ED crisis of 2014/2015 would not have had an impact on patient morbidity and mortality. We know that with Severe Sepsis, respiratory failure, cardiac failure, the unconscious patient and renal failure time is off the essence. In this time period we have patients waiting longer in ambulances and EDs, followed by a period of time where they may not necessarily be in the type of acute medical bed that would best serve their needs. The current death rate in England and Wales is running about one-third higher than its normal rate for this time of year, and this has been a relatively mild winter.

Whilst SAHF was rapidly rolled out due to the perceived risks of continuing with the status quo and the impact this would have on lives, I have yet to see a risk assessment of outcomes following the closer of the first 2 EDs. I believe in November it was stated that an external review would take place of the ED crisis in NW London but this has failed to materialize or at least as a front line acute physician I have not been approached to provide evidence for this review.

Capacity and capability of community and out of hospital services

An emergency is not always as clear as a heart attack or asthma attack. When an elderly patient with early signs of dementia takes an electric kettle and places it on a gas hob an acute emergency situation has arisen. A patient who falls and is unable to get up of the floor could present with muscle damage and renal failure as well as hypothermia, but could equally highlight a failure in social care in the community when the spouse struggles to get them up again. The majority of acute medical admissions represent care of the elderly emergencies both medical and social. What is very clear to Physicians working on the front line is that care in the community is not adequate to care for many of these patients and they will inevitable stay in hospital for prolonged periods of time awaiting adequate social services input. Length of stay for 50% of patients in the hospital would frequently be greater than 10 days.

SAHF had a vision for care in the community, which would mean patients could be looked after in their own homes and in the community without the need for acute hospital admissions. This vision has not materialized, if anything the impression is one of reductions in services. We have fewer social workers on our wards. Community nurse vacancies are high (approximately 40%) and district nurse visits are frequently cancelled. Intermediate Care visits designed to support patients in the community are cancelled or staff are seconded to district nursing to fill the gap. It is difficult to get patients into rehabilitation beds or community step down beds and frequently once in these beds the patients are readmitted back to the hospital due to worsening clinical conditions.

Funding for nursing and residential homes is lacking and frequent disputes are arising between hospital staff and social services relating to patients mental capacity. Social services are declaring the presence of capacity so that patients would not require nursing home placements. Doctors, nurses, therapy staff and relatives are increasingly feeling uncomfortable with this situation and are not happy to discharge patients into the community where a place of safety has not

been identified. This bed blocking results in a further exacerbation of the ED crisis as there is no space on hospital wards for patients to move into from the ED.

Central Government financial support to Ealing Council has been significantly reduced with the council needing to make savings of 46% over the next 4 years. A Consultation is currently taking place on changes to public health services in Ealing with proposed reductions in drug and alcohol services, sexual health (including HIV support and prevention) and school nursing services. Day care centres for mental health patients in the community are closing, once again impacting on the wellbeing of the most vulnerable and marginalized in society.

One of the outcomes of the IRP was to ensure that adequate investment had occurred in community and out of hospital services before Ealing and Charing Cross EDs would close. How is this currently quantified? It maybe argued that the current NW London ED crisis is not due to the closer of the 2 EDs but due to the bed blocking crisis but this is still a failure of the SAHF program due to lack of adequate community services and social care.

This was a mild winter Norovirus and Influenza infections as well as cold weather did not impact the community as bad as it could have, yet the health infrastructure was gridlocked. There was a lack of space in EDs to assess patients and on the roads outside to park ambulances. SAHF once fully instigated would result in the loss of approximately 1000 hospital beds in NW London; it is inconceivable how a health infrastructure would function with this loss of beds and no buffer capacity to deal with a severe winter or seasonal viral infections.

Staff morale, vacancies, agency staff and the Ealing brain drain

I am certain if the commission has read the submission from Ealing midwives you will have some insight into the depths to which staff morale has plummeted. SAHF has placed an axe over the hospital making it difficult to recruit and retain staff and in some circumstances leading to almost whole teams being made up of agency staff.

Ealing hospital has a long tradition of infiltrating into the heart of the community it serves and knowing the populations diversities and needs like no others could. Historically teams from the endocrine department have been door to door in Southall studying and seeking diabetes cases. Departments such as the Cardiology Department that has tirelessly researched the local population with multiple peer reviewed papers are effectively being shut out of the future shaping of community health care even when it has been acknowledged that pilot projects in community cardiac rehabilitation have been successful (appendix F).

SAHF needs to stop, pause and assess the risks of ED closures, lack of community and social services and the loss of faith they have incurred in local health care professionals. The process must listen to the wisdom of the workforce that has dedicated itself to the service of Ealing's community.

Yours Truly

G. S. Sandhu

Dr. Gurjinder Singh Sandhu DTM&H, PhD, MRCP
Consultant Infectious Diseases and Acute Medicine

The People's Enquiry for London's NHS.

27/2/14

Dear Sir/Madam

I'm writing to you as a Consultant in Infectious Diseases and General Internal Medicine. I have concerns about poverty, austerity and Infectious diseases.

I express these concerns at a time of hospital reconfigurations in NW London with the planned closure of 4 Emergency departments. These closures come at a time of unprecedented political interference with the NHS, following from the 2008 Global economic crisis.

I will begin by illustrating my concerns with lessons from overseas.

Lessons from overseas

In the United States from 1998 to 2008 the total number of emergency departments declined 3.3% from 4771 to 4613. In this same period, ED visits increased by 30%. Hsia et al found a higher risk of emergency department closure for departments that serve communities of uninsured patients, patients in poverty and ethnic minorities (1). The concept of a "safety net hospital" is described as a hospital that organizes and delivers a significant level of health care and other related services to uninsured, Medicaid and other vulnerable patients. EDs at safety net hospitals were more likely to be closed than EDs at non-safety net hospitals.

The result was reproduced on a regional level in California; each increase of 0.1 in the proportion of black individuals using an emergency department increased the odds of ED closure by 41%. (2)

In there findings the authors conclude that it is economic and market based approaches to health care that result in the closure of emergency departments in deprived areas and create wider health inequalities.

Taking into account the PFI debts in NWLondon hospitals, changes introduced with the Health and Social Care Act and the ability of foundation trusts to increase private work capacity up to 49% it is apparent that it is market forces that are driving emergency department closures in NWLondon. In figure1 we see how in NWLondon the risk of closure of emergency department is directly proportional to the level of deprivation in the community.

There are further lessons to learn from Greece, I will simplify by quoting directly from the articles:

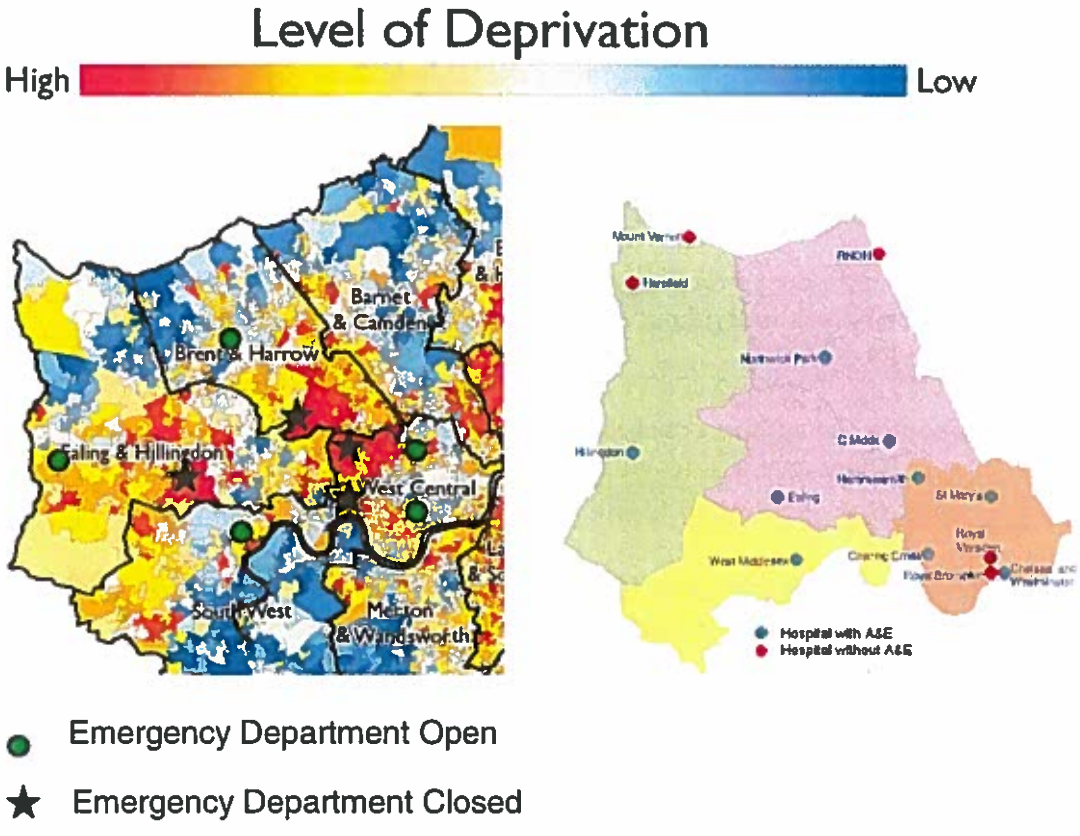
"Austerity measures lead to reconfigurations resulting in elimination or merging of 370 specialist units, reduction in public hospital beds from 35 000 to 33 000 (and a further 500 beds were designated for priority use by private patients), a freeze on hiring new physicians, and permission for private doctors contracted with the insurance fund to work in public hospitals once weekly."

"The proportion of people in Greece who felt that they needed but did not access medical care rose significantly; long waiting times, travel distance, and waiting to get better were the main reasons given for not seeking care. Such responses are substantiated by reports of 40% cuts to hospital budgets, shortages of staff and medical supplies, and corruption in health care" (3,4)

In Greece there are clear signs that health outcomes have worsened, especially in vulnerable groups with a HIV outbreak in injecting drug users, a 40% rise in suicides between January and May 2011 compared with the same period in 2010. There has also been a rise in homelessness and crime.

It is estimated that the NWLondon reconfiguration will result in a loss of approx 1000 hospital beds; with further planned reconfigurations in London leading to even more bed losses. The Health and Social Care Act would allow doctors in remaining trusts to increase the proportion of private work performed to a far greater level than the Greek scenario.

Figure1 Level of deprivation and risk of Emergency Department closure

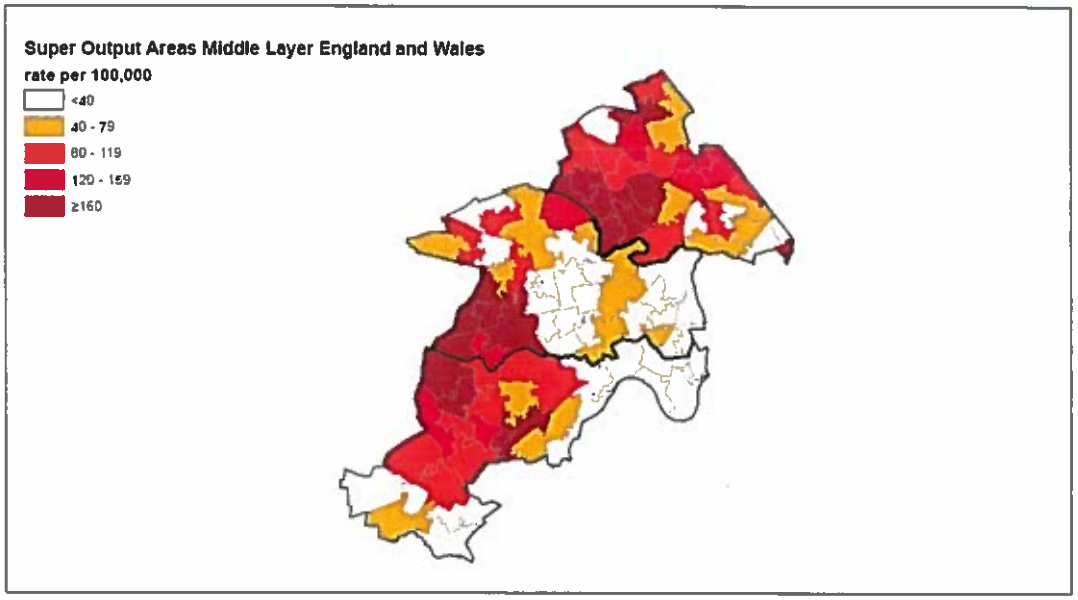


Tuberculosis:

In the most ethnically diverse parts of NWLondon the rate of Tuberculosis (TB) is similar to rates in the 22 WHO high burden countries. The number of TB cases in London is nearly seven times the next highest number in Western European cities. The HPA London TB 2011 report shows hotspots in Brent, Ealing and Hounslow with TB rates >160/100,000, similar to rates in India, Nigeria, and Tanzania. TB is further complicated by issues of stigma, malnutrition and poverty; these are compounded further by risks of substance abuse, mental health and homelessness. One in ten cases of TB in the UK have at least one social risk factor (drug use, alcohol use, homelessness, or imprisonment), leading to increased susceptibility or contact with TB

Currently with the health seeking behaviour of our population 52% of adult TB cases present via the emergency department. Over half (55%) of migrants diagnosed with TB in London are of working and childbearing age (20-39 years), leaving families susceptible to medical poverty traps. Levels of poverty have reached Dickensian magnitudes, with one malnourished TB patient found by St Mungo's outreach workers wrapped in a carpet sleeping under a bush in a park. Welfare reforms are leading to further examples of absolute poverty, with multiple food banks established in Ealing's Religious Institutions.

TB incidence 2011 by MSOA for Brent, Ealing and Hounslow



Deprivation and the Elderly

Income deprivation in Southall has been worsening since 2007 and 58.7% of pensioners in Ealing receive state benefit only. Incapacity and disability allowance has increased in each ward in Ealing since 2008. People of advanced age are the most vulnerable to the health implications of cold weather and 10.1% of households in Ealing live in fuel poverty with a higher excess winter death index compared to London and England in people over 65.

In July 2013 several media outlets reported on a dramatic rise in deaths among elderly patients in the past year, particularly in deprived areas.

http://www.guardian.co.uk/society/2013/jul/25/labour-investigation-deaths-older-people

"There have been 600 deaths a month more than expected throughout the last year. The rise began at the end of 2011 and has only this month dropped back to the level that would normally be expected.

Over the past 18 months, there have been 23,400 more deaths than expected, which is a 5% increase."

Danny Dorling, Professor of human geography at Sheffield University: "The point is that it does fit austerity. The key is the suddenness of this. If it does drop now and go back to levels that have been normal in recent years, it doesn't look like a cuts thing. But my guess is that the biggest thing will be cuts."

Poverty is shifting from the centre of London to the outskirts yet across London it is in these areas where clinical networks between a Hospital, GPs and Social Care is being dismantled. The needs of the elderly, mental health patients and the disabled are being ignored. Austerity kills and alongside many of my Consultant Colleagues at Ealing Hospital this was a concern we raised.

Expressing medical concerns:

On 11th February 2013, the Consultant body at Ealing Hospital wrote to Jeremy Hunt urging that "The recommendation to downgrade Ealing Hospital to a local hospital with a stand-alone urgent care centre and outpatients with the loss of all its acute services is unsound, based on evidence which is unfounded and on a deeply flawed consultation which chooses to ignore the basic tests said to underpin these reconfigurations. There is no robust alternative provision for acute medical needs, either by other acute providers or in the community. We have grave concerns for the safety of our patients and the impact on their quality of care if these proposals are carried out."

On 30th October 2013 the Secretary of State for Health, Jeremy Hunt announced to the House of Commons that he accepted the advice of the Independent Reconfiguration Panel (IRP) on the 'Shaping a Healthier Future' proposals for NHS reorganisation in North West London "in full".

Mr. Hunt referred to letters he had received supporting the proposals from all eight clinical Commissioning Groups involved and the Medical Directors of nine local NHS Trusts.

Mr. Hunt's decision was influenced by the letter signed by the Medical Directors of the trusts in North West London. The letter states: "We know that providing seven day services will save lives" and goes on to state "delays expose patients to serious risk". The Telegraph reported on this letter with the headline "Close A&E's to save lives, doctors urge Jeremy Hunt", while the BMJ's headline stated: "Doctors support biggest local reconfiguration in NHS".

Similar assertions were made on the 31st of January 2013 when the Secretary of state for Health initially announced the downgrading of Lewisham A&E department with the assertion that reconfiguration would save 100 lives a year.

As soon as the reconfiguration in NW London was announced it rapidly became a blueprint for the rest of London and the country, with assertions that the NHS was "unsafe and unsustainable". Rapidly clause 118 was being rushed through parliament, eliminating any consultation with the populations most impacted by hospital reconfigurations.

The Medical Staffing Committee of Ealing Hospital has been strongly and publicly opposed to the reconfigurations. It was our experience that when expressing concerns about the lives that would be lost due to austerity, increased distance to an emergency department or overcrowding of emergency departments we were stopped by assertions from NHS NWLondon that this was scaremongering. Doctors in managerial positions, however, were able to lobby politicians and push for rapid reconfigurations on the assertion that lives will be lost.

The magnitude of the injustice which has occurred in NW London epitomises the attack which NHS patients and staff face on a daily basis across London and the rest of the country.

The Francis Forum:

Across the NHS staff are feeling the impact of cuts, whether this be to services, staff levels or entire hospitals. A culture of fear is still paramount, preventing staff from speaking up. Where views are expressed staff are up against a conglomeration of managerial voices that are focused on finances and have the ability to lobby politicians at the eleventh hour to push through agendas.

This ethos in the NHS takes us back to the essence of the Francis report: a culture focused on doing the system's business – not that of the patient.

We have set up the countries first "Francis Forum" at Ealing Hospital. An environment which encourages whistle-blowing as the norm with a focus of putting the patient at the centre of everything we do.

We welcome the People's Enquiry for London's NHS as a similar platform uniting staff, patients and relatives and look forward to reading the outcome of the report.

Yours truly

Dr. Gurjinder Singh Sandhu DTM&H, PhD, MRCP

Consultant Infectious Diseases

(1). Factors Associated With Closures of EmergencyDepartments in the United States JAMA, May 18, 2011—Vol 305, No. 19 Hsia et al

(2). System-Level Health Disparities in California EmergencyDepartments: Minorities and Medicaid Patients Are at Higher Risk of Losing Their Emergency Departments - Annals *of* Emergency Medicine 2011 .Hsia et al

(3). Financial crisis, austerity, and health in Europe. Lancet 2013; 381: 1323–31. Karanikolos et al

(4). Health effects of financial crisis: omens of a Greek tragedy Lancet Vol 378 October 22, 2011. Kentikelenis et al

From: The consultant body at Ealing Hospital

To: Rt Hon Jeremy Hunt MP

Secretary of State for Health

Department of Health

London

10 February 2013

Dear Mr Hunt,

We write to you as physicians and consultants in Acute, Elderly and Speciality Medicine, Surgery, Maternity, Paediatrics, Radiology and Pathology at Ealing Hospital NHS Trust (EHT).

This letter details our major concerns about the current proposals as contained in "Shaping a Healthier Future" (SHF) and explains how this will disadvantage the population served by Ealing Hospital. As you know, the SHF plans involve the reconfiguration of hospital services in NW London. The consultation finished in October and the stated preferred option of NHS NW London (option A) has always been the closure of the Accident & Emergency departments at Ealing, Charing Cross, Central Middlesex and Hammersmith, alongside downgrading their acute services. We would like to specifically comment on these plans as they relate to Ealing Hospital. At the start of this process, the Prime Minister visited the hospital to announce the launch of the NHS Health and Social Care Bill so it seems to us ironic that this very hospital will become one of the biggest casualties of the largest reconfiguration of healthcare services in the UK to date.

In April 2011 Ealing Hospital merged with local community services as an integrated care organisation (ICO). This merger was supported by NHS Ealing and NHS London specifically to improve local provision of integrated care to our vulnerable population. Now less than 2 years later the proposal in SHF to remove acute services from Ealing Hospital will reverse the progress that has been made and impede access to high quality local care. The trust also has a locally–responsive maternity service on – site which will be lost. Ealing maternity services have been developed for the last thirty years around the specific health-needs profile of the complex population it serves.

A summary of why this process has failed is as follows:

1. The SHF consultation process failed to support Option A.

We believe that the SHF consultation process was flawed, based on inaccurate information, and failed to demonstrate that Ealing Hospital satisfies the tests necessary for reconfiguration Option A to proceed. The figures obtained by the consultation are simply a by-product of a deeply flawed process which pitted hospital against hospital, doctor against doctor, borough against borough and not surprisingly created winners and losers.

In particular:

[a] ***It failed to demonstrate public approval and that it will improve patient safety***: nearly 100, 000 people have signed petitions against the reconfiguration. Your predecessor, The Rt Hon Andrew Lansley stated that elderly people in any given population, as the major users of healthcare, should have more of a say in local reconfigurations. The elderly of Ealing will be particularly disadvantaged by the SHF plans and their views have been ignored. It has also failed to address the health complexity of the population and will disadvantage black and ethnic minorities. Removal of the acuter services currently available will mean that local people are denied access to an organisation which has worked hard to meet National Targets and improve patient safety. For example, it has demonstrated a sustained reduction in Healthcare-acquired infections over recent years. We have recently been passed by the Care Quality Commission and have consistently had safe rankings in the Doctor Foster guide.

[b] ***It failed to demonstrate GP approval***: Only 4% of GPs in Ealing Borough approved of the NHS NW London preferred option A. The CCG has also confirmed that in the face of the opposition to the proposals by the majority of its member practices, it would withdraw its formal support and currently backs the development of Ealing Hospital as a major acute hospital site. In a free vote conducted by primary care physicians from across the Borough last year, not a single GP present endorsed the view that Ealing A&E should close. The Ealing Hospital Board has reaffirmed its previous statement that a major acute hospital on the Ealing site would best suit the needs of the local population (similar to Option C of the consultation).

[2] **SHF ignores the basic facts about the population who use Ealing Hospital**

We believe that SHF's plans fail to accurately take into account the nature of the population using Ealing Hospital, their health care needs and health-care seeking behaviour.

Ealing is the 4th most ethnically diverse borough in the UK, with large communities from the Indian Subcontinent, Somalia and Eastern Europe. Black and minority ethnic (BME) communities comprise 46% of Ealing's total population. This compares to approximately 35% of Greater London's population. Ealing also falls within the top 20% most deprived English Local Authorities with significant health inequalities within the borough itself. In the 2011 Community Health Profiles Ealing scored significantly worse than the England average for indicators such as: child poverty, child obesity, alcohol-related hospital admissions, drug misuse, people diagnosed with diabetes, new cases of tuberculosis, and early death caused by heart disease and stroke.

We are very concerned that the proposed reconfiguration will lose the good practice and expertise that Ealing Hospital has gained over the years in providing services to a wide variety of ethnic backgrounds as well as to frail, vulnerable elderly patients with complex co-morbidities.

There is very robust evidence for the effect of inequalities on health, but the SHF consultation failed to include an adequate Equalities Impact Assessment. Indeed, the Equality Impact strategic review for SHF published in June 2012, described itself as only "a rapid review of key issues based on secondary evidence", providing only preliminary commentary and observations. The SHF report highlighted the need for further work to be undertaken with the Somali, Eastern European and South Asian populations but did not begin to appreciate the disease burden in these groups. To illustrate this:

Coronary Heart Disease (CHD) is more prevalent amongst the South Asian population. South Asians are 50% more likely to die prematurely from CHD than the general population. Standardised mortality ratios for coronary heart disease increases 3 fold as you travel from the most affluent areas of Ealing to the most deprived.

Tuberculosis: In the most ethnically diverse parts of Ealing, the rate of tuberculosis (TB) is similar to rates in the 22 WHO high burden countries. The number of TB cases in London is nearly seven times the next highest number in Western European cities.

Diabetes: 6.5% of the population in Ealing is known to have diabetes with a predicted prevalence of 8.6%. This is projected to increase with upward trends in obesity and the high prevalence of South Asian and African-Caribbean people in Ealing. Individuals in the lowest socio-economic groups are 2.5 times as likely, and BME groups up to six times as likely, to develop diabetes compared with the general population.

Domestic violence: Southall Black Sisters is one of the UK's leading organizations for BME women. Their data suggest that Asian women are likely to tolerate domestic violence for, on average, 10 years before seeking help and that rates of suicide amongst BME women are up to 3 times the national average. The organisation highlights how the SHF proposals "fail to appreciate the reality of the lives of the most marginalised and vulnerable members of our society" Highlighting specifically the difficulties vulnerable sub groups face when accessing health services.

[3] **SHF significantly underestimates the impact of the closure of Ealing A&E.**

[a] ***Ealing's A&E/UCC partnership is currently effective:*** We believe that the local population is currently served well by Ealing's side-by-side A&E and Care UK's Urgent Care Centre (UCC), allowing the effective triage of all patients attending the department. However, despite the introduction of the UCC over a year ago, "type 1" A&E attendances at Ealing have remained static at around 46,000 per year. Of these 13,000 per year were admitted in acute and elderly medicine, accounting for the majority of all admissions to the hospital. These numbers indicate the severity of illness in the local population as well as the fact that the UCC has not made any difference to the numbers of patients actually requiring assessment by the A&E department. Replacing this arrangement with a stand-alone Urgent Care Centre downgrades Ealing to a so-called "local hospital" with the loss of the intensive care unit, coronary care unit and acute medical, surgical and elderly medicine services. This is of particular concern, as emergency admissions to Ealing Hospital from its immediate vicinity are among the highest percentage in the UK, yet the SHF plans would leave an area the size of Leeds (Brent and Ealing combined) without a local A&E department. As SHF considered the NHS NW London region in isolation, it ignored the proximity of Acute Hospitals near its borders in the overall provision of services.

[b] ***Local A&Es work well for the majority of emergencies:*** In addition, while we accept that there is good evidence that heart attacks, strokes and major trauma are best dealt with at centralized tertiary centres, as these cases require specialist equipment (e.g. angiography) and co-ordinated expertise. However, there is no evidence that this strategy can be extrapolated to the vast majority of emergency presentations, such as septic shock, heart failure, abdominal pain, poisoning, and acute asthma. Local A&Es have the capability to select patients who require more specialised care, ease the pressure on large units and stabilise patients in the critical immediate period.

[c] ***SHF data are wildly inaccurate:*** Our colleagues in the Emergency Department have already responded to the inaccuracies in the SHF proposals. Specifically, SHF estimated that 80% of patients currently seen in the A&E department who do not require admission could still be seen in a future urgent care centre. **This figure is manifestly wrong**. The true figure is 30% or less. There is

clearly a massive discrepancy between the admission figures which NHS NW London are assuming need hospital care and the actual figures when talking to clinicians looking after patients on a day to day basis. The accuracy of these data is central to the whole proposal, as the reconfiguration flies or falls on the capability of remaining services to manage capacity. Those responsible for running SHF at a senior level have failed to listen or take on board any of the concerns we have had as consultants actually looking after this population.

[d] ***Elderly and vulnerable patients will have reduced access to emergency services:*** The A&E departments of Northwick Park and West Middlesex Hospital are not easily accessible from Ealing by public transport. Many residents would have to take at least two buses and there is no train station nearby. Travel times to these A&E departments, are estimated 'without traffic' in the report and are unrealistically short for a densely populated urban area. Elderly patients from Ealing will be disadvantaged since their friends, family and carers will have difficulty visiting due to transport. It is our understanding that many elderly people in Ealing forced to take buses will be very disadvantaged by these changes and this goes against one of the major statements made by Rt Hon Andrew Lansley MP, who stated that the elderly should have a much stronger say locally on the reorganization of health services. Clearly their views have been largely ignored.

[e] ***Neighbouring A&E departments will be put under further strain:*** It is likely that the majority of emergency patients who would have attended Ealing Hospital would go instead to Northwick Park Hospital or West Middlesex Hospital. These institutions already have capacity constraints, particularly in view of the centralization of specialized services on those sites. Recent data for 4 hour waiting targets of A&E departments in NW London show that only Chelsea & Westminster Hospital meets this target consistently. Given this, it cannot be sensibly argued that closing so many emergency departments will lead to any improvement.

[4] SHF fails to address the lack of alternative provision for patients currently admitted to Ealing.

[a] ***SHF fails to demonstrate alternative capacity for acute admissions:*** We believe that medical patients currently seen at Ealing will be difficult to accommodate elsewhere if acute services are lost from the site. Surrounding hospitals will face an increased burden both in their A&E departments and in the medical wards, resulting in increased risk to patient care and potentially greater lengths of stay in other institutions. Indeed, those working at the frontline for this community have consistently made the case that the reconfiguration with Option A will result in much poorer patient outcomes and ultimately greater expense.

[b] ***SHF fails to describe how a Community based Care strategy would work in practice:*** SHF makes mention of a "Community-based Care Strategy", but beyond a general aspiration, there is no description of how this would be

implemented or how it would reduce the current number of admissions. There is no evidence given, beyond the anecdotal, for the assertion in the report that community-based care can result in a 30% reduction in acute admissions to hospital. Moreover, without the full support of local GP practices (see above), it is hard to see how this could be achieved.

Ealing Hospital NHS Trust, as a community-integrated organisation, is already engaged with admission avoidance. Several teams already provide support for patients in their own homes to prevent the need for admission. We fully support the development of any initiative to enhance out of hospital care and care closer to home, but there is no compelling evidence yet that this has had a significant effect on overall numbers of admissions. In fact, the evidence is that it may just prevent admissions from increasing at the same rate as the rise of the frail elderly population.

[c] ***Integrated care relationships may be lost:*** At present, residents of Ealing Borough admitted to Ealing Hospital have a shorter length of stay than patients admitted from other boroughs. Excellent existing relationships with social services in Ealing will be hard to replicate in neighboring boroughs, leading to a strong likelihood of an increased length of stay for patients admitted outside Ealing.

The integrated care of patients is particularly relevant to chronic diseases, such as asthma, ischaemic heart disease, COPD, diabetes, epilepsy and inflammatory bowel disease. All of these conditions can have acute exacerbations that often require admission. Patients admitted via distant A&E departments, will not be known to the physicians in these hospitals. In addition, many chronic conditions initially present as emergency admissions. It is clear that a lack of continuity of care results in a reduced quality of care.

[5] SHF fails to address the impact on education and training.

Ealing Hospital is well-regarded as a provider for undergraduate teaching and medical training. We have many post-graduate doctors in training. Closure of acute services has a significant detrimental effect on training which cannot be realistically provided in the setting of a non-admitting emergency facility or by an elective surgical centre; experience elsewhere in London has confirmed this.

[6] The Future for the Ealing Hospital site

It is likely that there will be wholesale loss of the site to the local community over time. The proposed 20 million rebuild for the Ealing site post reconfiguration, if built, will simply stand as monument to a failed process which did not address the health needs of the local community, was not embraced by any section and was rejected by all local clinicians working at the frontline in Ealing.

Conclusions

1. There is no local frontline primary care support for SHF proposals to downgrade Ealing hospital and nearly 100, 000 local people from across NW London have rejected the SHF proposals as outlined in option A.
2. There is no evidence that SHF proposals will improve outcomes or choice for patients.
3. There are grave concerns about lack of staffing in primary and remaining secondary care units as well as doubts about the ability to cope with proposed changes.
4. The downgrade will mean that there will be 52% more patients per A&E under the proposed closures for NW London. There is no evidence to support the fact that the new re-organisation will cope with this.
5. The health needs of the local population have been ignored.
6. Surrounding hospitals do not have the capacity to cope.

Within the last 2 weeks we in the medical profession are hearing about new breeds of emergency departments and indeed new "Specialist Health and Social Care Hospitals". We as front line Consultants do not feel comfortable with the speed at which changes are being made, the great loss of capacity for inpatient beds in London and lengthening A&E queues. Whilst there are repeated assertions that lives will be saved the clarification of this statement has never been offered and we welcomed the letter written by our professional Colleagues in Lewisham Hospital to Sir Bruce Keogh to scrutinise this evidence basis. Overwhelmingly it seems difficult to appreciate how these changes are anything other than financially driven.

The recommendation to downgrade Ealing Hospital to a local hospital with a stand alone urgent care centre and outpatients with the loss of all its acute services is unsound, based on evidence which is unfounded and on a deeply flawed consultation which chose to ignore the basic tests said to underpin these reconfigurations. There is no robust alternative provision for acute medical needs, either by other acute providers or in the community. We have grave concerns for the safety of our patients and the impact on their quality of care if these proposals are carried out.

Yours sincerely,

Jenny Vaughan

Frank Geoghegan

On behalf of the consultant body at Ealing hospital

CC Dr Andrew Mitchell, medical, director NHS London

Dr Chris Clough Chair of NCAT

Anne Rainsberry, NHS NW London

Duncan Selby, head of public health, England.

Central and North West London NHS
NHS Foundation Trust

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Ealing Hospital NHS
NHS Trust

Imperial College Healthcare NHS
NHS Trust

The Hillingdon Hospitals NHS
NHS Foundation Trust

Royal Brompton & Harefield NHS
NHS Foundation Trust

The ROYAL MARSDEN
NHS Foundation Trust

West London Mental Health NHS
NHS Trust

West Middlesex University Hospital NHS
NHS Trust

15 Marylebone Road
London NW1 5JD

22 October 2013

Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SWIA 2N8.

Dear Mr Hunt

Re. Shaping a Healthier Future

We are writing as the Medical Directors of all of the Acute and Mental Health Trusts in North West London.

We have previously written in February to affirm our commitment to the proposals that were to be considered by the Joint Committee of PCTs (JCPCT) in February 2013 and now want to reaffirm our agreement with the decision made by the JCPCT and our commitment to implementing this proposal in partnership with the GPs in the local CCGs.

We have carefully studied the evidence to confirm that moving to fewer acute sites will allow improved care by having consistent larger consultant delivered services. We were intimately involved in agreeing the model of care with five major hospitals across the region.

We recognise that some local people feel anxious about the changes but are certain that these changes will save lives, whereas delays will leave fragile services that expose patients to unnecessary risks. We know that providing seven day services will save lives and improve patients care and satisfaction.

We agree also that these necessary hospital changes need to be implemented alongside investment and improvements in General Practice, Community Nursing and Social Care Support Services as enabled by this programme.

Many of us have had the opportunity to express our views to the Independent Review Panel and we look forward to their carefully considered report.

We are clear that these changes need implementing as soon as it is safe to do so; Indeed delays expose patients to serious risk and several of the current services are clinically and financially unsustainable. We urge you to support their findings which we know will benefit our populations care.

Yours sincerely

Dr Stella Barnass
Medical Director, West Middlesex University Hospital NHS Trust

Dr Nick Broughton
Med Director, West London Mental Health NHS Trust

Prof Nick Cheshire
Med Director, Imperial College Healthcare NHS Trust

Prof Tim Evans
Medical Director, Royal Brompton and Harefield NHS FT

Prof Martin Gore
Medical Director, The Royal Marsden NHS FT

Dr Abbas Khakoo, Joint Medical Director
The Hillingdon Hospitals NHS FT

Dr Richard Grocott-Mason, Joint Medical Director
The Hillingdon Hospitals NHS FT

Dr Alex Lewis
Medical Director, Central North West London NHS FT

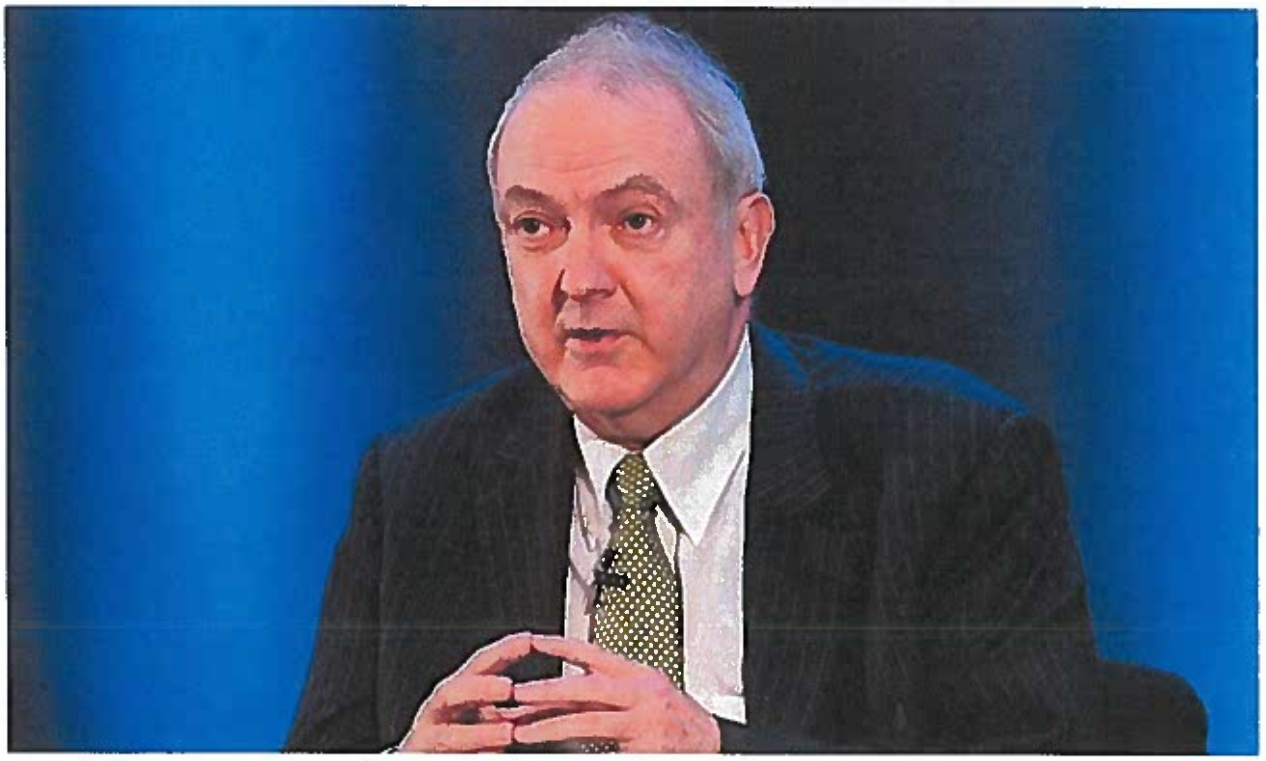
Miss Zoe Penn
Medical Director, Chelsea and Westminster NHS FT

Dr Alfa Sa'adu
Medical Director, Ealing Hospital NHS Trust

Cc Sir Bruce Keogh – Medical Director NHS England
Sir David Nicholson – Chief Executive NHS England
Dr Anne Rainsberry – Chief Executive NHS England (London)
Dr Mohini Parmar – Chair Ealing CCG
Dr Ian Goodman – Chair Hillingdon CCG
Dr Nicola Burbidge - Chair Hounslow CCG
Dr Ethie Kong – Chair Brent CCG
Dr Amol Kelshiker – Chair Harrow CCG
Dr Fiona Butler – Chair West London CCG
Dr Ruth O Hare – Chair Central London CCG
Dr Tim Spicer – Chair Hammersmith and Fulham CCG

'Control freak' Jeremy Hunt accused of manipulating NHS for political ends

Senior figures tell of fears that health secretary has torn up coalition pledge to make service operationally independent



Sir Bruce Keogh, the NHS's medical director, is said to haver clashed with Jeremy Hunt. Photograph: Joe Giddens/PA

Denis Campbell, health correspondent

Thursday 27 March 2014 22.30 GMT

Last modified on Tuesday 3 June 2014 09.31 BST

The health secretary Jeremy Hunt has had a series of standoffs and rows with NHS leaders amid claims from senior figures in the service that he is an interfering "control freak" who is trying to manipulate it for political purposes.

Senior NHS figures have told the Guardian privately of their fears that Hunt has torn up the coalition's pledges to "liberate"

the NHS from political control and make it operationally independent.

It is understood that Sir Bruce Keogh, the NHS's medical director, had to personally instruct Hunt not to announce his blueprint for restructuring A&E services in a highly charged encounter between the two last November.

Keogh and senior colleagues at NHS England, which is meant to be independent of Hunt's Department of Health, were annoyed that Hunt appeared to want to hijack Keogh's plan to announce the overhaul by unveiling the details himself first.

"Bruce basically took the secretary of state to one side and said 'bugger off'. There were some fairly tense conversations between Bruce and Jeremy Hunt at that time," said an NHS source.

NHS England leaders were also annoyed that when Hunt announced that hospitals in England would get an extra £250m to help their A&E departments cope with the winter, he gave them very little credit, even though they supplied the money.

But Hunt and the department declined to respond directly to claims by NHS figures that he is improperly "controlling" the service that is supposed to be run at arm's length following the controversial reforms instituted by his predecessor, Andrew Lansley. The Department of Health argues that he was doing the job expected of him.

A Department of Health spokesman said: "Jeremy Hunt makes no apology for taking a close interest in the performance of the NHS over winter, or indeed throughout the year. He is accountable to patients and to parliament and the public would expect nothing less."

Sources also say Hunt's staff also "leaned on" Anne Rainsberry, the chief executive of the part of NHS England responsible for London, to try to stop a controversial reorganisation of hospital services in north-west London because the prime minister was anxious about the downgrading of several A&E units in the area.

Rainsberry helped thwart that intervention by ensuring that medical directors of the eight NHS hospital trusts involved and the GP chairs of the eight clinical commissioning groups in the area wrote to Hunt outlining their support for the move. He later championed the shakeup as good for patient care.

Senior NHS figures also disclosed that they resent how Hunt holds twice-weekly meetings with the leaders of NHS England and two other key NHS organisations at which he directs them to look into issues of concern, provide more information, sort out problems and report back.

Regular "NHS delivery" meetings on Mondays focus on important areas of NHS performance such as A&E waiting times and financial problems, while the Thursday afternoon meetings instituted last October have concentrated on ensuring the service functions well during the winter.

Leaders of NHS England, Monitor, which regulates foundation trust hospitals, and the NHS Trust Development Authority (TDA), an arm of the Department of Health that oversees all other trusts, routinely attend the meetings.

However, some who do so, especially at NHS England, feel Hunt is improperly impinging on their freedom, especially in light of the autonomy they are supposed to have.

Sources speaking on condition of anonymity claim he is "micro-managing" the NHS, a practice the coalition explicitly promised to end.

But the Department of Health said that Hunt was entitled to hold such meetings. "It is absolutely right that he has regular updates from the key NHS organisations and the opportunity to discuss their plans," it added.

When Hunt began directly calling bosses of hospitals that were not meeting A&E targets last November, David Prior, the chairman of the Care Quality Commission NHS regulator and a former Conservative MP, said the health secretary was "crazy" and criticised his "obsession" with targets.

Managers in key NHS organisations such as NHS England and the TDA feel they are being "walked over" as a result of Hunt's

very hands-on style, according to the head of their trade union. Jon Restell, chief executive of Managers in Partnership, said: "They are very concerned. They feel they are being walked over by the Department of Health and that some of their independence is being ignored."

Concern extends to some of the members of NHS England's board. Lord Adebowale, one of the organisation's nonexecutive directors, said the balance of power between it and Hunt is a cause of concern.

"I've always said it would be hard to manage the strategic relationship between the NHS and the secretary of state [after the NHS reforms], given his responsibility to parliament," he said.

"It's a challenge, it's bound to be, managing that relationship. Of course it's something I worry about as a nonexecutive director." Hunt was perfectly entitled to ask for meetings with leaders of NHS England, he added.

Andy Burnham, the shadow health secretary, claimed that Hunt "seems to have forgotten voting to turn the NHS into the biggest quango in the world and now tries to disown the logic of his own policy. He talks in public about ending political interference, but in practice spends an afternoon making phone calls to chief executives of hospitals missing A&E targets."

04 February 2013

Professor Sir Bruce Keogh
NHS Medical Director

Dear Professor Sir Bruce Keogh,

We noted with great interest your letter to the Secretary of State for Health dated 30th January 2013[i] following his request for an independent clinical view on the recommendations by the Trust Special Administrator (TSA) for South London Healthcare NHS Trust (SLHT). The Secretary of State for Health's decisions were influenced by your advice, including the amendments made to the TSA's recommendations regarding Lewisham Healthcare NHS Trust.

We write with particular reference to the Secretary of State's decision to recommend the downgrading of University Hospital Lewisham's (UHL) emergency admissions and maternity services. We consider it a matter of public interest that you make available the evidence on which you have based your advice to the Secretary of State. This advice may ultimately have proved pivotal, since it has underpinned the assertions he made during the announcement to parliament on 31 January and has therefore provided clinical justification for the changes now proposed at UHL.

1. We would be grateful if you would supply us with the clinical evidence behind the Secretary of State for Health's claim[ii]:

   "Already, her constituents who have a stroke or a heart attack do not go to Lewisham hospital. They go to Tommy's or Guy's or other places where those specialist services can be delivered, and they get better treatment. We are expanding that principle through what I am announcing today, and it will save around 100 lives a year. That is something that she should welcome."

   In your letter to the Secretary of State, there is no mention of, or clinical justification for, the assertion that extending 'that principle' would save around 100 lives a year.

   We have investigated the origin of this assertion. A similar assertion has been made by NHS London: *Adult emergency services: Acute medicine and emergency general surgery; Case for change.*[iii] In pages 16-17, the main source for this assertion is the analysis performed by Aylin et al of the Dr Foster Unit at your own institution[iv] of 4.3m emergency admissions from 2005-6. Reference is also made to smaller studies which present similar results [v vi vii].

The interpretation of the Aylin study by NHS London ([viii]page 17) is as follows:

In a national study Aylin et al found that this effect is of the order of 10% nationally for in hospital mortality, and may be even greater if the period extended to 30 days post admission.

London data is [sic] in line with these findings. This suggests that across London there will be a minimum of 500 deaths each year which may be avoidable if services functioned more effectively.

From the Aylin study, the excess mortality for England is estimated as 3369 deaths. We can see how, proportional to population share, a London figure of 500 can be derived from this by NHS London as above, and a figure of 100 could be derived for SE London for use by the Secretary of State for Health.

But if we examine the Aylin study itself from which this figure was derived, there are fundamental flaws with this deduction.

<u>The calculation of excess mortality makes an unwarranted assumption:</u>

On the assumption that patients admitted at the weekend have the same risk of death as those admitted on weekdays, we estimate a possible excess of 3369 deaths (95% CI 2.921 to 3.820) occurring at the weekend for 2005/2006, equivalent to a 7% higher risk of death.

This is indeed a heroic assumption: that patients admitted as an emergency to hospital have the same risk of death (prior to admission) as patients admitted during the week. In the discussion, the authors themselves acknowledge the limitations of this assumption:

There could have been differences in case mix between patients admitted during the week and at weekends. We attempted to take some account of case mix in our model, but there may be still some residual confounding, which could lead to either an overestimation or underestimation of risk. There were indeed fewer patients admitted on average at the weekend, and this might point to a different case mix for which we have not adequately adjusted.

A major weakness of the study is the lack of calculation of severity score of the presenting illness. This cannot be resolved without the source data. A proper analysis would also require the severity score at time of admission and the duration from point of admission to death. The fact that the daily emergency admission rate at the weekend is only 75% of that during the week may well indicate that patients who present at the weekend are a sicker subset of those who present through the working week, with heir more severe illness explaining their higher mortality. That the weekday-admitted and weekend-admitted groups were matched for age, sex, co-morbidity and deprivation in no way proves that the severity of the presenting illness leading to death was equivalent. A more recent study[ix] has found similar differences in mortality in patients admitted at the weekend, in particular Sunday, but has cautioned against the interpretation that this is as a result of differences in quality of care.

A second weakness is the assumption that higher mortality in patients admitted at the weekend results from a decreased level of staffing at the weekend. There are other explanations, including a reduced level of specialist intervention and access to diagnostic services at weekends. It is noteworthy that Lewisham Hospital has had a robust system of twice-daily consultant ward-rounds and access to out-of-hours diagnostics for 8 years.

The conclusion made by the Secretary of State is therefore not founded on robust clinical evidence. It is troubling that such an unsafe conclusion could be used to make an assertion that has obviously influenced his decision, not just in the case of Lewisham Hospital but in general, that larger units will achieve better clinical outcomes.

2. We would also be grateful for your urgent clarification of the evidence for the following assertions made by Mr Hunt in parliament[x]:

   To meet the London-wide clinical quality standards, which are not being met in south-east London at present, it is necessary to centralise the provision of more complex services in the same way that we have already successfully done for heart attacks and strokes. That principle applies as much to complex births and complex pregnancies as it does to strokes and heart attacks, and it will now apply for the people of Lewisham to conditions including pneumonia, meningitis and if someone breaks a hip. People will get better clinical care as a result of these changes.

   Our maternity care is well-regarded: of women booked into antenatal care at Lewisham, there have been no maternal mortalities in the past 7 years. This is despite the fact that high-risk pregnancies form the majority of our maternity workload[xi]. A free-standing midwifery-led birthing unit at Lewisham could only be expected to accommodate low-risk women who had already had at least one baby (RCOG, 2011), amounting to only 12% of the present total, rather than the "up to 60%" claimed by Mr Hunt.

   You may in fact be unaware, or have not informed the Secretary of State, that UHL is in fact one of the highest performing Trusts nationally for the management of hip fractures.

   Guidance on the management of meningitis emphasise the speed of administration of definitive treatment and not the size of the hospital it is treated in. Furthermore, a recent UK study of over 19,000 patients with meningococcal disease shows that mortality is the same (4.9%) whether the patient is admitted during the week or at the weekend[xii]. Neurology guidance recommends that that the patient with suspected bacterial meningitis should be transferred immediately to the nearest secondary care hospital[xiii]. There is therefore no basis in clinical evidence for the assertion made by the Secretary of State.

   The overall standardised hospital mortality index for UHL is 0.91 (NHS Choices), which compares favourably with hospitals in the South London Healthcare Trust. Lewisham ICU is one of the better performing ICUs in the country[xiv]

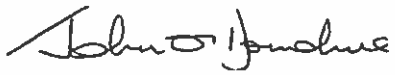
We are aware of the need for financial prudency and the drive towards the proposed clinical standards. Our alternative proposal put to the TSA was that the future merged Lewisham/ Greenwich Trust would achieve these clinical standards and within budget, but retain its discretion to allocate emergency and elective services across the Lewisham and Woolwich sites as commissioners require.

We are sure that you, a fellow medical professional, would agree that the evidence-base upon which we practice should be sound in order to deliver high-quality care to our patients. This duty extends to those members of the profession, like you, who have put themselves forward to provide medical advice on matters of public policy. This is especially true where that evidence is being used to inform a decision on reconfiguration and centralisation of acute services: if the clinical evidence base is wrong, or the deduction from the evidence is flawed, patients may actually be harmed. We believe that there is a significant risk of this resulting in Lewisham, if high-quality local emergency services are withdrawn in the mistaken belief that they will be provided to a higher standard elsewhere.

Your advice to the Secretary of State may also have a profound impact nationally if these specious grounds for centralisation of most emergency admissions are accepted, and as a result other high-quality DGHs are sacrificed as a result.

We believe that the clinical evidence underlying last week's decision is deeply flawed, and therefore call on you to reconsider urgently your advice to the Secretary of State.

Yours sincerely,



Dr John O'Donohue, Consultant Physician, Lewisham Healthcare NHS Trust

Dr John Miell, Consultant Physician and Director of Service for Specialist Medicine, Lewisham Healthcare NHS Trust

Dr Tony O'Sullivan, Consultant Paediatrician and Director of Service for Children

Dr Elizabeth Aitken, Consultant Physician and Director of Service, Acute and Emergency Medicine, Lewisham Healthcare NHS Trust

Mr Dan Zamblera, Consultant Obstetrician and Director of Service, Women and Sexual Health, Lewisham Healthcare NHS Trust

Mr Nabil Salama, Consultant Surgeon and Director of Service, Surgery and Anaesthesia, Lewisham Healthcare NHS Trust

Dr Chidi Ejimofo, Consultant, Emergency Dept, Lewisham Healthcare NHS Trust

Miss Ruth Cochrane, Consultant Obstetrician, Lewisham Healthcare NHS Trust

Dr Asra Siddiqui, Consultant Neurologist, Lewisham Healthcare NHS Trust

Dr Richard Breeze, Consultant Intensivist and Director of ITU, Lewisham Healthcare NHS Trust

Dr Louise Irvine, General Practitioner, Lewisham PCT

References

[i] https://www.wp.dh.gov.uk/mediacentre/files/2013/01/SLHT.pdf

[ii] Hansard-31 Jan 2013: Column 1080, the Right Hon Jeremy Hunt, in reply to Dame Joan Ruddock

[iii] http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

[iv] Aylin P, Yunus A, Bottle A, Majeed A, Bell D. Weekend mortality for emergency admissions. A large, multicentre study. Quality and Safety in Health Care 2010; 19:213-217

[v] Bell, M. D., Redelmeier, D. A. (2001). Mortality among patients admitted to hospitals on weekends compared with weekdays The New England Journal of Medicine 345: 9

[vi] Barba, R., Losa, J. E., Velasco, M., Guijarro, C., Garcia de Casasola, G. & Zapatero, A. (2006). Mortality among adult patients admitted to the hospital on weekends The European Journal of Internal Medicine 17: 322-324

[vii] Riciardi, P. (2011) Mortality rate after non-elective hospital admission. Arch. Surg. 2011; 146(5): 545-551

[viii] http://www.londonhp.nhs.uk/wp-content/uploads/2011/09/AES-Case-for-change_September-2011.pdf

[ix] Freemantle N, Richardson M, Wood J, et al. Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine. Published online on February 2 2012

[x] Hansard, 31 Jan 2013 : Column 1081

[xi] In 2012, there were 4,129 Lewisham deliveries: 898 women delivered in our Birth Centre, of whom 509 were multiparous women.

[xii] Mortality from meningococcal disease by day of the week: English national linked database study J Public Health (Oxf) 2013;0:2013 fdt004v1-fdt004 RCOG (2011) http://www.rcog.org.uk/what-we-do/campaigning-and-opinions/statement/rcog-statement-results-npeu-birthplace-study

[xiii] EFNS guideline on the management of community-acquired bacterial meningitis: report of an EFNS Task Force on acute bacterial meningitis in older children and adults. European Journal of Neurology 2008, 15: 649–659 doi:10.1111/j.1468-1331.2008.02193.x

[xiv] www.ICNARC.org

Independent Review of SAHF Proposals

Commissioned by London Borough of Ealing

Tim Rideout is a former NHS Chief Executive and now an Independent Consultant and has expertise in reviewing Service Reconfigurations. He was commissioned by the London borough of Ealing to externally scrutinise the Shaping a Healthier Future (SaHF) proposals put forward by NW London NHS.

Mr. Rideout considers the proposals to be flawed particularly with respect to the specific health needs of the borough and to whether the local health system will be able to cope with the unprecedented scale of change.

References are made to the Rideout Report in this summary which is available in full on the Ealing Council website at www.ealing.gov.uk

1). The impact of the proposed hospital reconfiguration on the health of people living and working in Ealing does not appear to have been assessed.

The hub of the core argument for reconfiguration is: "there are significantly improved outcomes for patients and improved patient experience when certain specialist services are centralised". However this theoretical hypothesis has not been tested against the actual outcomes and current patient experience in NW London. (6.3.4)

The EIA (equality impact assessment) highlights the risk that, following hospital reconfiguration, such good practice may not be replicated by the "new" receiving hospitals and this may reduce local confidence in the post-reconfiguration arrangements. The EIA's assessment is that this is likely to have the greatest impact on BME (Black Minority Ethnic) groups.

Access is very important for the health of the population living and working in Ealing borough and poorer access, given what we know of their health seeking behaviour, will affect their health outcomes.

In order to evaluate the options for SaHF, a number of criteria were developed, with reported input from clinicians and patients.

While the final criteria are broadly sensible, interestingly a number of criteria suggested by clinicians and patients were not accommodated, including integration of services, health equality across NW London, and support for preventative care and help for patients to manage their own conditions.

There is no evidence that the proposed hospital reconfiguration will enhance patient choice of care. (6.3.6)

2). The report indicates an increasingly challenged primary care system with GPs and nurses required to provide an even greater range of services for a larger number of people.

The crude number of GPs within the Borough has risen at around 1.45% year-on-year since 2004, slightly lower than the national rise of 1.72%. However, this is compared to an estimated year-on-year growth rate in GP consultations of 2.8% nationally and an increase in the average number of consultations per patient per year of 2.7% year-on-year.

The health seeking behaviour of this population has not been taken into account and significant energy and time would need to spend "re-educating" the public to make different choices. NHS 111 will not be able to meet these needs and indeed there is emerging evidence to show it increases the burden on over-stretched Emergency departments.

The work/investment required to reduce demand for local A&E department is far more pronounced than for neighbouring boroughs. (7.7.30)

Ealing may face a shortage of GPs: Without replacement talent, primary care services will not be able to provide the manpower or skills required to meet local need, particularly as the range of services expected to be delivered by them expands. (7.7.35)

3). Currently the eight CCG level strategies for Out of Hospital (OOH) care are generic and lack sufficient detail to support implementation.

Central to all of the potential options is a significant shift of care from hospital care to primary and community care. There is insufficient evidence that the primary and community care developments will deliver sufficient capacity and capability to support such change. The anecdotal evidence collected during the production of this report indicates a high level of uncertainty (from managers and clinicians) about primary care and community care's ability to deliver the shift in care from local hospitals. Specifically the proposed model of care, based on the establishment of new standalone Urgent Care Centres and GP networks, is very largely untested and unproven.

4). There is evidence that indicates the "over-provision" of A&E departments is not as marked as claimed.

The whole UK population is served by 240 Type 1 emergency departments for a population of 62.3m people. That equates to 259,425 people per A&E. NW London currently has 8 Type 1 emergency departments, serving a population of just under 2m people. That equates to 247,150 people per A&E, 5% less than the national figure. Should the reconfiguration proposals proceed NW London will be served by 5 Type 1 emergency departments. That would equate to 395,440 per A&E, 52% more than the national average. (7.3.7)

Comparisons should not just look at the size of population but also the relative complexity and need. It is not clear if this assessment is based on a comparison with similarly complex and growing populations. (7.3.9)

5). Failure of this (SaHF) analysis to consider the impact of redirected patient flow from downgraded hospital towards designated major hospitals is of great concern.

The summary of current A&E activity details a total of 946,671 episodes in 2010/11. The modelling of patient flows however takes into consideration the projected changes in A&E volume based on the proposed plans and estimates total activity in 2014/15 to be 748,500 episodes comprising 372,000 (A&E major and standard) and 376,500 (A&E minor – presumably to be treated by an UCC). This represents a decrease of 21% in 4 years, or an annual reduction of 6%. This is open to challenge as it is overly optimistic given that A&E admissions in London have historically risen by about 3% per year.

6). The underlying assumption of GP support for SaHF plans is open to challenge.

The support of the "shadow" CCG chairs and their boards to consultation does not automatically equate to their support or the support of the grassroot GPs for SaHF. In recognition of this, ECCG has decided to ballot the Ealing practices and if the majority of practices oppose the proposals then the ECCG Governing Board has given an undertaking to formally withdraw its support. **This position is not reflected in the business case.** (6.2.4)

NHS
Ealing
Clinical Commissioning Group

Mr David McVittie,
Chief Executive,
Dr Amarjit Sethi,
Consultant Cardiologist
Ealing Hospital NHS Trust,
Uxbridge Road,
Southall,
UB1 3HW

23 Oldfield Lane South
Greenford
UB6 9LF

Tel: 020 3313 9444
Email: rajchandok@nhs.net

12th June 2014

Dear Mr McVittie and Dr Sethi,

Future of the ICP funded cardiology rehabilitation pilot at Ealing Hospital

As you may be aware in January 2013 Ealing Hospital NHS trust cardiology department applied for, and won, a bid for monies for a small pilot cardiology rehabilitation programme for patients from ethnic minorities. The funding from North West London Integrated Care Pilot (ICP) has now come to an end and Ealing CCG has considered the options available.

At the Ealing CCG Executive committee on 11th June, the future of the cardiac rehab pilot was debated. We recognise that the service has demonstrated a clinical improvement in the functional capacity of patients who have participated. However the ICP funds for 2014/15 are now fully committed to other work-streams and after considering the options, Ealing CCG Executive decided not to take over funding of the pilot scheme.

Ealing CCG is however, fully committed to commission a cardiac rehabilitation service as part of our planned cardiology procurement. The new rehab service (as part of the new community cardiology service) starting in 2015 will be specified in line with NICE guidelines, and include capacity for all suitable patients post admission. In addition there will be a proactive exercise based programme for patients to reduce cardiology admissions.

We would like to take this opportunity to thank the Trust and Cardiology Department for their hard work in delivering the pilot service to 40 patients. The results have shown benefits for patients but the service current delivers only 4% of required capacity and expanding the service at this stage would be a significant draw on trust and CCG resources while a cardiology procurement is in process.

NHS
Ealing
Clinical Commissioning Group

Dr Amarjit Sethi,
Consultant Cardiologist
Ealing Hospital NHS Trust,
Uxbridge Road,
Southall,
UB1 3HW

23 Oldfield Lane South
Greenford
UB6 9LF

Tel: 020 3313 9444
Email:

16th June 2014

Dear Amarjit,

As the CCG lead for ICP, I wanted to take this opportunity to thank you and your colleagues personally for piloting cardiac rehabilitation with the ICP and to express my personal regret that the funding has come to an end.

The time and effort involved in bidding, setting up, delivering and evaluation a pilot scheme can be significant. The service has demonstrated benefits to the patients who have participated. I was particularly impressed by the positive impact on the psychological wellbeing of patients. This is too often an area chronic disease management which is overlooked. As a result of the pilot, the CCG is committed to using the learning from cardiac rehabilitation pilot to inform the development of a comprehensive cardiac rehabilitation service for the people of the borough which is being led by Dr Alex Fragoyannis and Delia O'Rourke.

Once again I would like to thank you and your colleagues for running the pilot service.

Yours sincerely

Dr Raj Chandok - CCG Vice Chair and ICP lead, Ealing CCG

Copies to:
Olivier Molloy - Clinical Nurse Specialist for Cardiac Prevention & Rehabilitation, Ealing Hospital NHS Trust
Dr Mohini Parmar, Chair, Ealing CCG
Kathryn Magson Managing Director, Ealing CCG
Mr David McVittie Chief Executive, Ealing Hospital NHS Trust
Prof Jaspal Kooner, Cardiologist, Ealing Hospital NHS Trust